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ABSTRACT

Local education agency responses to student pregnancy and parenthood are constrained by narrow definitions of the problem, opposition to sex education, contraception, and abortion, disagreement about the appropriate school role, lack of expertise, and lack of incentives to develop programs. Nationwide field studies were conducted to assess 12 local school programs for pregnant and parenting students in terms of federal, state, and local constraints, program design, school responses to student pregnancy, and the impact of these factors on students' decisions about school continuation. Results indicated that: (1) schools do not seek or want an active role in student pregnancy or parenthood; (2) special program initiation is generally dependent on the dedication of a single individual; (3) quality is uneven within and across programs; (4) each special program model, whether included in, supplementary to, or extracurricular to the school curriculum, is unable to meet all the diverse needs of pregnant students and teenage mothers; (5) pregnant students make most decisions about pregnancy and school continuation without school staff input; and (6) few programs conduct outcome evaluations to assess their effectiveness or to examine the longer-term impact of adolescent parenthood. (Author/HLM)

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# The Response of the Schools to Teenage Pregnancy and Parenthood

Gail L. Zellman

April 1981

Prepared for the National Institute of Education

U.S. DEPARTMENT OF EDUCATION
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# PREFACE

This study reports on the response of a major societal institution—the public schools—to the phenomena of teenage pregnancy and parenthood in its midst. These phenomena are far from new, but until recently they have been viewed as exclusively personal matters of little or no direct concern to the larger society. A number of factors, however, including the increasing percentage of all births accounted for by teenage mothers, an increase in out-of-wedlock births, and evidence of adverse effects on welfare and school dropout rates, have made teenage pregnancy and parenthood matters for societal concern.

The passage of Title IX of the 1972 Education Amendments, which included in its mandate equal rights for pregnant and parenting students, and growing acceptance of early pregnancy and parenthood by teenagers themselves, have compelled some institutional response to these matters from the schools.

This study of the schools' response, sponsored by the National Institute of Education under Contract No. 400-78-0064, was designed to examine these responses by the schools from the perspective of educators, community members, and parenting adolescents.

# SUMMARY

## BACKGROUND AND OBJECTIVES

Teenage pregnancy and childbearing have long been familiar phenomena, but until recently have been considered exclusively personal matters. They have now become a recognized social problem, however, because of several factors, including an increase in the rate of out-of-wedlock births to teenagers, more sexual activity among young people, and data that show the high personal and societal costs of early parenthood.

Perhaps these factors alone would have sufficed, eventually, to motivate a widespread response by the schools, but the schools were overtaken by events. The passage of Title IX of the 1972 Education Amendments, which mandated equal treatment of pregnant and parenting students, and growing acceptance of early pregnancy and parenthood among teenagers themselves, have compelled the schools to make some institutional response.

Local education agency (LEA) responses to student pregnancy and parenthood are constrained by a number of factors, including narrow (usually medical) definitions of the problem; opposition to sex education, contraception, and abortion; disagreement about the appropriate school role; lack of expertise; and lack of incentives to develop programs.

The federal, state, and local policy context in which school district policies and programs are developed reflects these constraints. The federal government has allocated some funds for support of local programs, but has failed to provide national leadership or support for innovative program efforts. Several states provide substantial funds to local programs, but leadership is generally lacking, and both legislation and policy inhibit equal educational opportunity in some states. Few local school districts have formal pregnancy policies, and transfer and absence policies may reduce the likelihood that teenage parents will complete school.

In view of the many constraints, the creation of a special program to serve pregnant and parenting students must be viewed as a major achievement. This report examines 12 of these local programs. Data collection was oriented toward three objectives:

1. *To understand how pregnant junior and senior high school students decide whether to drop out of school, to continue in school with little interruption, to marry, or to remain single.*
2. *To assess the current role of schools in the decisions of pregnant and parenting students to continue in school.*
3. *To determine whether there are exemplary programs, schools, or school districts that have effectively served the many needs of pregnant students and teenage mothers.*

## METHODS

We conducted field studies in 11 school districts around the country. Each district had established a formal program to serve pregnant students or teenage mothers; one district ran two programs.

The 10 programs and two exemplary programs we visited fall into three types, which vary in their underlying rationale and their relation to the regular school curriculum:

- *Inclusive Curriculum Programs* represent 7 of the 12 programs we visited. They offer enrollees both a general education curriculum and a range of "relevant" coursework, e.g., parenting, child development. Counseling, child care, and other services may also be offered. These programs assume that pregnancy is a highly stressful period for teenagers, and provide support and protection during this period in a separate environment. Few provide continuing services after delivery.
- *Supplementary Curriculum Programs* provide "relevant" coursework for school credit to enrollees receiving general educational services in regular classes. Other services, such as child care and counseling, may also be provided. The rationale of these programs is that young mothers can best learn to function in their new role as parent in a regular school environment. Much of the focus is on the period after delivery.
- *Noncurricular programs* are not credit-granting, though they may provide "relevant" instruction and other services. Enrollees attend regular school, though program services may also be available to dropouts. Noncurricular programs concur with supplementary curriculum programs that mainstreaming is the best approach, and that the post-delivery period is as important as the period of pregnancy, if not more so.

## FINDINGS

### Special Programs

Many barriers impede the initiation of a special program for pregnant students and teenage mothers. Surmounting those barriers depends largely on the dedication of a concerned person in the district. In the most successful programs, this person has been able to convince the superintendent and others of the need for the program.

Program design usually depends on the personal views of the prime mover and the superintendent; few districts conduct a search for alternative program models. Outside funding sources dictated the program model in only a few cases.

Although special program staff rarely were concerned about the comparability of their program to that provided to nonparenting students, the inclusive curriculum programs are not comparable in many ways. They are located in central city areas, usually in older, abandoned schools. As a consequence, suburban students tend not to enroll. Most of the physical plants are run down and rarely provide access to the handicapped. Instructional equipment is often outdated or lacking.

Staff, however, appear dedicated and highly qualified in most programs. Program resources go disproportionately to staff, with pupil/teacher ratios in the seven inclusive curriculum programs averaging 13 to 1. As a result, inclusive curriculum programs are often costly, though in several cases these costs are borne in large part by outside agencies, usually states.

Few programs conduct comprehensive evaluations of their effects on enrollees. Project staff everywhere reported that they want to evaluate, but do not do so for lack of funds. Many school district administrators see no need for evaluation, however, and do not pressure staff to do so. It is apparent, nevertheless, that the program models themselves have competing strengths and weaknesses. Inclusive curriculum programs provide enrollees a warm, protective environment, but end rather abruptly soon after delivery. Enrollees must transfer out and back into regular school; many students disappear in this process. Noninclusive programs avoid transfer

problems and continue services after delivery, but cannot provide a sheltered environment away from school.

Most programs appear to have a secure future in the district, since the decision to initiate a program reflected a long-term district commitment. Costs may constrain continuation, however, if outside funds become unavailable; in these cases, superintendent support may figure prominently in a program's long-term stability.

### Exemplary Program Models

Site visits were made to two noncurricular programs we characterized as "exemplary" in terms of five process criteria, including percent of eligible students served, level of coordination with community agencies, quality of resources, level of district support, and quality of services provided. Program K assigns each enrollee a counselor who coordinates all needed services. Few services are provided directly by the program; its goal is to use existing community services to promote school continuation. Program L locates primary care medical clinics in high schools. The clinics serve all enrollees of the high schools in which they are located, provide the children of students with pediatric services, and run a child care center. Their goals are to improve prenatal care and prevent unwanted teenage pregnancies. A third program, although not well implemented, has an "exemplary" model in which program social workers, backed up by a team of concerned faculty, provide enrollees with counseling, referrals, and information in a regular school setting.

The three exemplary program models share several strengths, including a commitment to provide services through pregnancy to graduation, to provide services regardless of what decision the pregnant teenager reaches on resolving the pregnancy, and to serve a high percentage of those eligible. Program K also offers services to dropouts.

### School Site Policies

Student pregnancy and parenthood are rarely discussed in the 30 regular schools we visited; few schools have comprehensive policies designed to help parenting students maintain school attendance. Practices, however, are remarkably similar across schools. Most of them are directed toward helping a pregnant student enroll in a special program; few policies or procedures exist for working with students past this point in a pregnancy. Counseling is limited, and focuses most often on school program selection. Pregnancy resolution decisions and dropout decisions are almost always left to pregnant students and their families.

Title IX has had little effect on school site policies regarding pregnancy and parenthood in the schools we visited. Many regular school staff were not aware of its implications for student pregnancy and parenthood. Those best informed generally construed the mandate of Title IX very narrowly; in most cases, nonexclusion was seen as the only implication of Title IX in this area.

The generally passive response of regular schools to student pregnancy and parenthood reflects widespread views among staff that pregnancy and parenthood are primarily the responsibility of the student, not the schools. Many staff believe that the special program is a sufficient school response, and that program enrollees who return to regular school after delivery can function effectively without special help. Most staff believe that, whatever the initial capability of a pregnant student, becoming a parent will inevitably reduce her educational and vocational success. Having "wasted" her potential, many staff do not want to invest a great deal of effort in her.

### The Views of Parenting Adolescents

In the course of our fieldwork, project staff interviewed 121 young parents about pregnancy, parenthood, school, and careers.

In our sample, norms regarding sexual behavior were ambivalent. Many respondents told us that sexual activity is expected and "everyone does it," but that involvement in sexual activity is often withheld even from close friends. Most were fairly knowledgeable about contraception, but this knowledge did not automatically lead to contraceptive practice. Reasons for nonuse varied widely; in a few cases, nonuse was motivated by a desire for a child.

In spite of nonuse (or ineffective use) of contraceptives, many respondents were shocked when pregnancy was confirmed. Most were also afraid of parental reactions. In the majority of cases, however, parental reaction was far more benign than expected; parents were typically reported as disappointed but resigned. Peers were generally supportive and accepting; in only a few cases did pregnancy bring social ostracism. Respondents generally found school staff to be neutral about pregnancy, with some positive and negative exceptions.

In our sample of adolescents who kept their children, no more than three could be said to have given open consideration to all four pregnancy resolution options: abortion, carrying to term and relinquishing for adoption, carrying to term and keeping the baby as a single mother, and marrying and assuming wife and mother roles. Many were "keepers" because they had strong anti-abortion attitudes, and did not consider adoption as a serious choice. Few interviewees chose marriage, though this option often received careful consideration. Marriage was usually rejected because respondents believed it would exacerbate an already difficult situation by isolating them from a supportive family environment.

Once the carry-and-keep decision has been made, educational decisions are tackled. The decision to drop out or continue with school almost always was made prior to informing the school of the pregnancy. These decisions depended heavily on personal motivation and peer and family pressures. If the decision was to continue, a pregnant student would contact school staff to inquire about available educational options. Those who decided to leave school often did so without contacting school staff.

Decisions about where to attend school usually were made on the basis of program features. Those who chose an inclusive curriculum program found parenting-oriented coursework, individual attention, and flexibility appealing features. Those who chose to remain in regular school usually did so to remain among friends and to continue advanced or specialized classes. In a few cases, negative program features, such as transportation problems, motivated continuation in regular school. Most students liked the programs in which they were enrolled. Strong regrets were heard only from those who realized later they had made an uninformed choice.

The effect of parenthood on respondents' lives varied considerably. For some, the effect was slight, the inconveniences few, and the benefits large. For others, pregnancy and parenthood brought enormous changes and many problems. However, there was near consensus on one point: If they had it to do over, nearly all said they would not become pregnant, or would abort a pregnancy.

## CONCLUSIONS AND POLICY IMPLICATIONS

Given the many factors constraining school district response to student pregnancy and parenthood, the presence of a motivated person seems a necessary condition for the establish-

ment of a special program serving this group. Given a leadership vacuum at the federal, state, and local levels, the form and quality of this person's ideas usually determine the form and quality of the district's program.

As the major funding source for a number of local programs, State Education Agencies (SEAs) and other state agencies are in a unique position to provide substantive leadership for local efforts in this area. Few, however, have chosen to do so. A stronger state role could help to reduce the people-dependence of local programs, the resulting lack of programs in many LEAs, and the variation in quality across programs.

Federal staff, particularly those at the Office of Adolescent Pregnancy Programs (OAPP), could support state-level efforts to improve local program quality by using federal funds to develop, document, and evaluate a range of program models. Federal funds might also be used to develop and strengthen practitioner networks, which could lobby at the state level and provide technical assistance and support for local programs.

At the local level, the superintendent could play a major role in establishing expectations that the district can and should attempt to meet the needs of parenting students. Principals could have much the same effect in schools by discussing student pregnancy and parenthood and emphasizing the positive contributions that regular school staff can make.

There is clearly a role for the schools in student pregnancy and parenthood. For even the most motivated parents, a host of extrinsic problems can make school continuation difficult; for those less motivated, the problems may make it impossible.

The inclusive curriculum program model, which for many is synonymous with special programs for pregnant students and teenage mothers, is costly and often inefficient. Thought should be given to other program models that provide many services at less cost to the district.

Adolescents are also changing. Although their needs are great, pregnancy is not as embarrassing as it once was to many; the isolation afforded by an inclusive curriculum program may be seen as a negative rather than a positive program feature.

In their efforts to succeed in the district, special program planners frequently ignore regular school staff. No matter what model the special program follows, regular staff can reinforce and multiply its effectiveness, or reduce it through their actions and inactions. Time spent eliciting the active cooperation of regular faculty, nurses, and counselors is time well spent.

## ACKNOWLEDGMENTS

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# Chapter 1

# INTRODUCTION AND STUDY OBJECTIVES

This study reports on the response of the public schools to the phenomena of teenage pregnancy and parenthood. The analysis, which is based upon field studies in 11 school districts across the country, is the final product of a Rand study sponsored by the National Institute of Education.

## BACKGROUND OF THE STUDY

Early pregnancy and childbearing are phenomena of long standing, but until recently they have been viewed as exclusively personal matters of little or no direct concern to the larger society. Clinical evidence pointing to the negative consequences of early pregnancy and parenthood for the health of mother and child legitimized some specialized response by medical institutions, but the involvement of other sectors was not considered or discussed.

Increasingly, however, teenage pregnancy and parenthood have been seen as matters of more general interest and concern. Several factors have contributed to their growing prominence as a social problem. One is prevalence. Zelnik and Kantner (1980) note that the percentage of their 15-to-19-year-old metropolitan area respondents who reported a premarital pregnancy increased from 9 percent in 1971 to 16 percent in 1979. A number of reports suggest that the average young woman runs a significant risk of becoming pregnant during her teenage years (e.g., Wexler, 1979; Tietze, 1978). Another important factor is that, in recent years, births to teenagers have come to represent an increasing percentage of all births. While this apparent increase is largely accounted for by an increase in the proportion of teenagers in the population and the decline in the birthrate among older women, few media reports note its relative status (Eisen, Leibowitz, Zellman, Chow, and Evans, 1980). In fact, the birthrate for older teenagers is also declining (National Center for Health Statistics, 1980). However, despite increased contraceptive usage, birth rates to the youngest teenagers have not declined in recent years (National Center for Health Statistics, 1979; Baldwin, 1980). The public is probably most alarmed by this trend.

Increased sexual activity among teenagers has also attracted public attention. Surveys indicate that growing numbers of teenagers of every sociodemographic group are having intercourse (Zelnik and Kantner, 1977, 1978, 1980).

Increases in the percentage of out-of-wedlock births to teenagers have been cited as evidence of the "epidemic" nature of the problem in a veritable deluge of articles in the popular press. Out-of-wedlock births to women under 20 rose from under 100,000 in 1960 to almost 250,000 in 1978 (National Center for Health Statistics, 1980). This upturn, however, is not so much the result of an increased rate of conceptions to unmarried women as it is of choices by pregnant teenagers not to marry. The percentage of conceptions that led to marriage decreased by 54 percent between the 1960-64 and 1970-74 periods (Baldwin, 1977). Many concerned workers in this area applaud the decreasing incidence of marriage; they cite a number of studies indicating that early and precipitous marriage usually worsens the longer-term outlook for the

teenage mother and her child (e.g., Moore et al., 1979). The general public, however, views these trends with alarm.

The public's concern is understandable. Several studies affirm that teenage pregnancy and parenthood have clear, long-term societal implications. Teenage mothers are more likely to be on welfare than women who defer a first birth, and are more likely to have large families (Urban Institute, 1980). Teenage mothers are also more likely to drop out of school, which is itself associated with welfare status (Moore et al., 1979).[1] Incidence of low-birth-weight infants and infant mortality rates are higher among the offspring of young mothers (National Center for Health Statistics, 1980). Surviving children may still show decrements in terms of tested intelligence, school achievement, and psychological and social adjustment, largely because of the social and economic impact of an early birth on their parents (David and Baldwin, 1979; Baldwin and Cain, 1980).

One cannot say whether the demographic and other factors discussed above would have been sufficient to motivate a widespread response by the schools. In the past, public secondary schools have added many specialized functions and taken on roles traditionally performed by other institutions and agencies. Today, however, many educators believe that the schools have been unfairly burdened with society's problems and cannot continue to assume such burdens if they are to perform effectively their unique task—academic training (Tyack, 1979; Warren, 1972).

In the past, many school professionals were acquainted with the statistics on teenage pregnancy, but the schools made little response.[2] Most pregnant students were dropped from school early in their pregnancy and were discouraged from returning after they became parents. Few efforts were made to encourage school continuation or completion (Klerman and Jekel, 1973).

Some forces, however, encouraged action by the schools.[3] Notable were the women's movement and growing emphasis in the society as a whole on acknowledging the special needs of minority and other interest groups. An increased incidence of childbearing among middle-class students may also have contributed to the momentum. Two other developments, however—one in the policy area, one concerning social norms—have pressured the schools into making some institutional response.

The first of these developments was the passage of Title IX of the 1972 Education Amendments.[4] Title IX had immediate implications for school treatment of students who became pregnant. Title IX mandated that pregnant students have the same rights and responsibilities as any other students. Specifically, pregnant students could no longer be expelled from school or barred from any school program, course, or activity solely because of pregnancy. Students could reenter school at any time after delivery. Under Title IX, pregnant

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[1]As the proportion of young people completing high school has risen, the negative impact of school dropout has become more evident (Vinovskis, 1979).

[2]A 1968 survey by the Children's Bureau found only 35 programs for school age mothers across the country (Klerman and Jekel, 1973).

[3]Indeed, by 1972 the Children's Bureau reported over 200 programs for school age mothers (Klerman and Jekel, 1973).

[4]Title IX specifically prohibits discrimination on the basis of sex in schools receiving federal funds, which includes virtually all public schools. Most public interest in Title IX has focused on its sports policy: Coaches strenuously objected to the diversion of athletic monies to athletic programs for female students. Its less well known pregnancy policy specifies that pregnant students must be treated the same as other students with regard to enrollment, reentry, and assignment to classes. Pregnant students could not be required to take courses related to pregnancy or child care, though schools were permitted to offer special courses and programs. The instructional portion of these programs had to be comparable to those offered nonpregnant students. (See Zellman, 1981, for further discussion of Title IX and teenage pregnancy.)

students and teenage mothers could no longer be excluded from school; student pregnancy and parenthood were now legally school matters.[5]

The passage of Title IX resolved (at least in a limited way) a long-standing conflict between the view that a primary responsibility of the schools is to engender sound moral principles, principally by excluding unsavory moral elements, and the tradition of public schools' inclusiveness (Warren, 1972). Title IX affirmed pregnant and parenting students' right to equal educational opportunity, even at the expense of the exercise of the schools' moral training function. Although pregnant students and teenage mothers might have an undesirable influence on their peers, they now had a legal right to attend school.

The second major development that induced school policy change was a substantial change in attitudes, particularly among teenagers, toward premarital sex, unwed pregnancy, and marriage. A variety of data point to growing tolerance in our society as a whole for sex and childbearing outside of marriage. Indeed, celebrity unwed mothers have made the phenomenon almost chic. Census data indicate that the number of households containing two unrelated adults of opposite sex increased 117 percent between 1970 and 1978 (U.S. Bureau of the Census, 1979).

Among teenagers, sexual intercourse is often more acceptable than sexual abstinence (Zellman and Goodchilds, forthcoming). Pregnancy more often brings positive than negative sanctions from peers. Regardless of their views about the desirability of unwed pregnancy, few teenagers see marriage as a solution. Indeed, those who marry to "resolve" a teenage pregnancy are seen as foolish, and marriage is regarded as simply making things worse. Given these views, pregnant teenagers generally see less reason to conceal a pregnancy than they did a generation ago. At least some decide to continue in school and often do so with increased determination, for soon there will be a child to support.

## CONSTRAINTS ON SCHOOL RESPONSE TO STUDENT PARENTHOOD

Most educators are sensitive to these attitudinal changes and the resultant increase in the number of pregnant and parenting students in school. Most are also aware that exclusion is no longer legal. These two factors have combined to cause some response to student pregnancy and parenthood by many local education agencies (LEAs), but the responses vary enormously. One extreme is not-so-benign neglect. Aware that pregnant students and teenage mothers cannot be excluded, some school districts choose to ignore the problem, an inexpensive response that may actually discourage pregnant students and teenage mothers from attending school, thereby reducing the dimensions of the problem itself.

At the other extreme, some school districts have established independent full-service programs for meeting almost every imaginable need a young mother might have, from medical care and nutrition education to counseling and the three R's. Some innovative programs attempt to provide needed services, including child care, to pregnant students and teenage mothers who attend regular school programs.

Special programs of all kinds face many constraints and problems in the course of their initiation and implementation, but programs and policies regarding student pregnancy and parenthood face far more than most. The constraints and problems can alter the form and

[5]While Title IX did not require schools to make an affirmative response, other federal initiatives, e.g., the 1964 Civil Rights Act, which mandated equal educational opportunity, and PL94-142, the Education for All Handicapped Children Act, which mandated a "free and appropriate" education, created a legal climate in which special services for pregnant and parenting students, while not required, began to seem grounded in law.

content of an LEA's response to student pregnancy and parenthood and in some cases make any response impossible. Some of the most important of these constraints are discussed below.

### Narrow Problem Definition

A major constraint on school districts is the often narrow definition of the problem. Who will be served and what services will be provided are more often givens than they are subjects for open discussion.

Much of the impetus for serving teenage parents has come from the medical community. Obstetricians and pediatricians have noted the increased health risks to both mother and child associated with childbearing by teenagers. These risks have focused interest on the pregnant teenager and her fetus, and later on the newborn. Nonpregnant teenagers, even those who are sexually active and at risk of pregnancy because of nonuse of contraception, are of less concern. Similarly, the delivered mother is of less interest, except as she influences the health of her infant through feeding and other practices.

The medical perspective continues to dominate, even while other aspects, e.g., the long-term educational outlook for teenage mothers, have become more salient. Nearly all the school personnel we interviewed stated that early and adequate prenatal care is their primary concern in dealing with pregnant students—a laudable attitude in many respects, since good prenatal care can reduce the likelihood of birth complications and defects. Yet such a perspective ignores other important aspects of teenage parenting, notably prevention and the long-term health and welfare of the teenage mother.

One important reason for such a narrow definition of the client—first the pregnant teenager, then the infant—is that limiting service to the already pregnant and the newborn allows programs to sidestep controversies surrounding sex education, contraceptive dispensing, and abortion, while serving those with the most immediate needs. Said an activist in one of our sites about the district's program for pregnant students, "the program has been opposed by some people . . . but generally people are supportive if only because people feel that we need to be positively concerned with new life."

Limiting the clientele to the already pregnant or the newborn has resulted in program models that typically begin after pregnancy is discovered and come to an abrupt halt soon after delivery. (See Chap. 2 for a discussion of this model, which commonly underlies school-based programs.) Prevention is often ignored, and little attention is paid to the sometimes serious and certainly long-term obstacles that teenage mothers face in realizing their own ambitions while functioning as effective parents.

### Political Realities

Strong and vocal opposition to abortion, contraception, and sex education may also constrain an LEA's response. Right-to-Life groups are powerful and active in many states; these groups have been very effective with legislators, whom they threaten to connect with abortion, regardless of their views, unless they vote the view the group is pushing. As a result of such lobbying efforts, program planners and legislators try to avoid the abortion issue entirely. When they cannot, the issue is usually eliminated early as a part of the process of compromise and accommodation. Even strong proponents of abortion may acquiesce to its exclusion from legislation, policies, or programs out of concern for acceptance of the larger part. A typical exchange concerning abortion that highlights its unacceptability can be found in the hearings

before the Senate Committee on Human Resources on the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978:

> Dr. Peter Scales: Fourth, funds should be available for abortion.
>
> The Chairman: I will not get into your suggestion on making funds through this program available for abortion. I will just tell you that the practical legislative life will say no. The program would have imbedded its own death with that in this program (p. 610).

In some communities opposition to sex education is equally strong. One or two extremely vocal parents can cause a school administrator considerable difficulties.

The upshot of such political realities and the attitudes behind them is that many policy-makers and school administrators simply try to avoid these controversies. As a result, abortion becomes less available for pregnant women, particularly teenagers. Said Hendrixson (1979) of the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978, "None of the authorized funds may be used to pay for abortion—indeed, even counseling for abortion as an option is not mandated by the bill. . . . A faculty opposing abortion need only mention that the adolescent might go elsewhere for other counseling, not even indicating what those services are or where they can be found" (p. 664).

Sex education also is less available. Professionals in local communities, even if qualified and eager to provide these services to the schools (often without cost), may be barred from doing so. Sex education curricula, when they exist at all, focus on reproductive physiology and avoid discussion of intercourse, contraception, and abortion.

### Disagreement about Institutional Roles

Another important constraint on a school district's response to student pregnancy and parenthood is widespread disagreement and uncertainty about the proper role of nonmedical institutions in this area and related ones.

Most people agree that sexuality and sex education are private and family matters that ideally should be treated at home. Yet many acknowledge that the family is not always effective as a sex educator and look to other institutions, especially the schools, for help. Said Dr. George H. Thoms, school principal, in testimony before Senate hearings on the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978:

> We agree with those who argue that schools cannot and should not replace the personal relationship between parent and child or usurp the role of religious institutions. The schools, however, are the only institutions that reach practically all of our children and for a substantial period of time. The schools are organized and prepared to work with all the children, both the hard to reach and the easy to reach, the churched and the unchurched, and those who have confiding relationships with their parents as well as those who do not (p. 611).

Sex education programs in schools are far from universal. They are not even common. State legislatures have generally avoided this unpopular issue as much as possible. Only recently has sex education been mandated in even a few states. Consequently, the initiative for sex education must usually come from the local level, but obstacles also abound there. School staff often point to community opposition as the major constraint on providing comprehensive sex

education, but school staff attitudes also intervene. Although most teachers endorse sex education, few want to teach it themselves, and many do not feel qualified to do so.

A similar though less adamant resistance to involvement with pregnant teenagers characterizes all levels of the policy system. Some blame the "victims," others feel it is simply a matter that should be dealt with privately by teenagers and their families. Use of public funds for such aid seems inappropriate to many.

### Lack of Expertise

Lack of programming expertise also constrains school districts. As discussed in Chap. 2, local programs that serve pregnant students and teenage mothers usually owe their impetus to a single concerned person who pushes for a programmatic response. The resulting program reflects this person's view of the best approach. Rarely is the full range of program models considered; often no one knows what they are.

In a few cases, the content of the program is of little concern—the central goal is exclusion, and this is best met by a physically isolated program. More often, program implementers have nowhere to turn for data that demonstrate how well one model or another has worked elsewhere. Few programs perform long-term outcome evaluations; funds are rarely devoted to developing and testing innovative approaches. Few states have developed or demonstrated "model" programs; consequently, they are unable to make suggestions to local practitioners about an appropriate model. Program development leadership is similarly lacking at the federal level.

As a result, local programs tend to respond to the "conservative tendency" (Coleman, n.d.), which is said to characterize bureaucratic organizations generally and schools especially. Without evaluation data or program leadership at the state or federal level, local programs and policies are sometimes remarkably innovative, but more often are not; but however good a given local effort may be, there is no sense of building on a strong knowledge base.

### Lack of Incentives To Develop Programs

As births to teenagers increase as a proportion of all births, medical settings have an increasing incentive to serve this population. Other institutions, notably government and the schools, do not have such an incentive. As noted above, pregnancy prevention, pregnancy, and parenthood among teenagers are topics likely to arouse strong controversy. Interest groups that support human services to deal with these issues are few and less powerful than strong lobbying groups such as Right-to-Life. Any policy in this area entangles legislators in difficult issues such as contraception and abortion.

The schools also lack strong incentives to become involved. As McLaughlin (1976) notes, schools operate in a nonmarket setting in which there is no interorganizational competition. Students not served well by the schools may drop out (Camp, 1980) but the schools' survival is guaranteed by society. Federal regulatory legislation, notably Title IX of the 1972 Educational Amendments, forbids exclusion of pregnant students because of pregnancy, but does not mandate any affirmative actions. Many educators believe that to treat the problem is to admit failure. Conversely, absence of a policy or program conveys the impression (though not, of course, the reality) that the problem does not exist.

No unitary interest group exists at the local level to prod the schools into action. The parents of pregnant students are often grateful for any help the schools offer their "errant" daughters; parents of the not (yet) pregnant serenely assume that they will not face the

problem. The voices of natural advocates, e.g., March of Dimes Birth Defects Foundation, Planned Parenthood, and professional groups, are often overwhelmed by competing interests—of the school board in achieving a balanced budget, of the superintendent in addressing other more pressing problems such as a desegregation court order or keeping the district afloat financially. The short period of pregnancy and the fact that many pregnant students are close to graduation may further reduce inclinations to channel dollars and other resources to this group.[6]

Dollar incentives exist, however. In all districts, the school retains its state reimbursement for a student when she remains in school.[7] In many sites, additional state funds are available for special programs. However, as discussed in Chap. 2, these extra funds rarely serve as an incentive to initiate a program. School administrators believe that all special programs impose extra costs on the LEA. They also believe that a strong retention policy without a special program is costly in nonmonetary terms. For example, some counselors may resent the extra time pregnant and parenting students take from "good" students. Some staff feel that simply having pregnant students on campus lowers the perceived quality of the institution.

## BROADER POLICY CONTEXT

The federal, state, and local policy context in which local school district policies and programs are developed reflects the constraints discussed above. As a result, this context is often inhibitory, sometimes neutral, and only occasionally facilitative.

### Federal Level

Prior to the 1960's, there was a policy vacuum surrounding teenage pregnancy and parenthood at the federal level. During the 1960's, some federal funds began to be available for medically oriented programs whose main function was to provide prenatal care. Family planning and pregnancy counseling services were later outgrowths of these early programs. As births to teenagers became a growing proportion of all births in the 1960's, some increased attention focused on nonmedical aspects, particularly the effects of pregnancy and parenthood on schooling. A variety of federal funds supported the development and maintenance of more than 200 programs during this period (Sedlak, 1980). However, the needs of pregnant and parenting students were not considered in the major education initiative of that period, the Elementary and Secondary Education Act of 1965.[8] Parenting students were not explicitly

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[6]Many education programs designed to aid special groups, e.g., Title I, ESEA, focus on the early years in the belief that preventing deficits at that point will have long-term benefits.

[7]States provide funds to school districts on the basis of average daily attendance (ADA) or total attendance on a given "count" day. Thus, the LEA receives money when a student remains in school and loses it when that student drops out. However, this money is always less than the cost of educating a student and therefore the incentive value of this money is minimal at best. The fact that potential dropouts often have academic and adjustment problems further reduces the incentive function of these funds.

[8]The Elementary and Secondary Education Act (ESEA) of 1965 was the first major program of federal support for education. Title I was passed in response to concerns that children from economically disadvantaged backgrounds often did poorly in school and that the schools serving these children frequently lacked the resources necessary to meet their educational needs. Title I provides monies to state departments of education. They distribute the funds to local districts on the basis of a formula that includes the number of children in the district from poverty backgrounds and the average per pupil expenditure for education in the state. Within the district, Title I monies are to be spent on those students with the greatest educational needs. Some LEAs used Title I funds to support programs for pregnant and parenting students.

included in Title I, nor were student pregnancy and parenthood a priority under Title III.[9] The reasons for exclusion were clear—sex and pregnancy were still very private[10] events—but the effects unfortunate. The 1960's were a time of growth and enthusiasm for new programs. Programs today must be developed in a climate of retrenchment and doubts about the efficacy of special programs.

In the 1970's a number of events set the stage for an enlarged federal presence in this area. In 1970 the National Alliance Concerned with School Age Parents (NACSAP) was formed. Its goal was to lobby for programs and policies to aid teenage parents. NACSAP's particular interest was the schools. In 1971 a Federal Inter-Agency Task Force on Comprehensive Programs for School Age Parents was formed. Although it did not recommend any new programs, it represented federal interest in this issue (Family Impact Seminar, 1979).

In 1972, Title IX (of the 1972 Education Amendments) was enacted. This legislation, regulatory in character, established the legitimacy of a federal involvement in the schools' treatment of student pregnancy and parenthood. It mandated that the pregnant student has the same rights and responsibilities as any other student; it specifically prohibited expulsion or exclusion of pregnant students from any programs, courses, or extracurricular activities. It affirmed the right of pregnant students to remain in regular school programs throughout pregnancy and post delivery. Yet few educators, and probably fewer still in the general public, were aware that Title IX had any implications for student parenthood. School professionals continued to feel little or no federal presence in this area.

No affirmative federal action occurred until 1978, when Congress passed the Adolescent Health, Services, and Pregnancy Prevention and Care Act of 1978. This legislation noted that "federal policy . . . should encourage the development of appropriate health educational and social services . . . and the . . . coordination of existing services . . . to prevent unwanted early and repeat pregnancies and to help adolescents become productive independent contributors to family and community life." The legislation authorized the establishment of the Office of Adolescent Pregnancy Programs (OAPP), which would administer the Act. A main feature of the legislation was that, under Title VI of the legislation, grants were to be awarded on a competitive basis to provide and link local preventive, prenatal, and postnatal services to adolescents.

The practitioner response to the passage of this legislation was enthusiastic. In the first six months of OAPP's existence, it received more than 4000 letters requesting information and several hundred funding proposals (Nix, 1979).

The initial promise of OAPP has not, to this point, been realized. Because the legislation had not been passed by the time appropriations hearings were held for FY79, the Congress did not include funding for the proposed program in the FY79 budget. The Administration did request $7.5 million in its supplemental budget request, but only $1 million was appropriated and that amount was not approved until July 1979; therefore the new program was not fully operational in its first year. The FY80 appropriation of $17.5 million was far higher, but was also reduced, to $8.7 million. As a result of budget and staff cuts, the number of funded projects at this writing is only 27.

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[9]ESEA Title III Innovative Projects was designed to improve the quality of public education by introducing model practices new to American education and by spreading existing successful practices. Title III grants were awarded on a competitive basis and were open to almost any kind of project local schools wished to propose. Some Title III funds were granted directly to LEAs; remaining funds were allocated to state education agencies (SEAs), who in turn made grants to LEAs.

[10]Vinovskis (1979) notes that until the late 1960's federal and most state governments were unwilling to finance contraceptive services even for adults; these and related services for minors were highly controversial, politically dangerous, and often prohibited by state law.

Of equal or more concern to many is the policy direction that OAPP has taken. The legislation was initially criticized for taking on too much. Said one critic during Senate hearings on the legislation, "it has an inherent structural flaw, and that is it seems to me the bill is trying to do too much under one authorization. Everything from preventing pregnancies to caring for pregnant teenagers, to a rather amorphous goal of 'helping adolescents become productive independent contributors to family and community life'" (p. 597).

Dr. Lulu Mae Nix, director of OAPP, acknowledged the legislation's broad mandate in an interview in 1979 with Chicago Public Television producer Michael Hirsh.[11] "That's the primary role of my office—to try to get people to work together . . . to provide care for pregnant adolescents, and to prevent initial and repeat pregnancies." In practice, however, the program focuses on the period of pregnancy, an emphasis that reflects both Congressional intent and the background of the director.[12] Nix acknowledges this focus, though she attributes it to Congress:

> This legislation that my office is administering is primarily dealing with the problem of pregnant adolescents and their infants. . . . Congress definitely wrote the bill that way because they felt that funds were already available for teenagers who wanted to go to family planning clinics, but there were little or no funds available for girls who were becoming pregnant and carrying their babies to term. The major focus of this legislation is to provide services for those girls and care for those girls and babies.

Critics of OAPP complain that PL 95-626 gives "short shrift" to prevention (Scales, 1978). Others object to the focus on the relatively short period of pregnancy rather than the longer, often more troublesome, postdelivery period. "A girl is pregnant for nine months, but she's a mother the rest of her life," said the director of a school-based parenting program in a recent issue of *Ms.* (Leishman, 1980).

Critics have noted that the exclusive focus on service delivery will do nothing to advance theory or practice in this area. Even those who endorse its service delivery focus note that its support of scattered local programs will not help to reduce the already fragmented efforts in this area. Many believe that an agency like OAPP ideally should be sponsoring a broad program of research, but given that such research is not authorized in the legislation, OAPP should at least engage in information dissemination by publicizing innovative local program models. Instead, most of the discussion of program models by OAPP staff focuses on isolated comprehensive programs, which were first developed in the 1960s.

At the time of our fieldwork (October 1979 to May 1980), OAPP had achieved little in our sites beyond raising expectations of federal support for local programs. In the longer term, its time-limited funding policy (5-year limit, with a declining percentage of support each year) may reduce the incentive value of federal funds, except in communities already disposed to develop a program. One program director who had applied to OAPP for funds told us that the superintendent had warned her that she could not count on the LEA to assume costs as OAPP support declined. More stable state entitlement funds may exert a greater influence on local program development, as discussed below.[13]

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[11]The interview was filmed for the documentary "Guess Who's Pregnant? An Update," which was shown on public television stations in 1980.

[12]The major debate in Congress surrounding PL 95-626 was between those who wanted to use the funds for prevention and those who proposed to use them for aiding teenagers who were already pregnant. The latter group prevailed.

[13]Bloc grants and weakened federal service mandates may influence the direction OAPP takes under its new Director.

**State Level**

A number of state-level policies may affect LEA programs and policies for pregnant students and teenage mothers. A policy of obvious significance is whether, how, and how much state money is available to fund special programs. Another important set of policies concerns the legal status of pregnant students and teenage mothers in terms of attendance and services entitlement.

State financial involvement on behalf of pregnant students and teenage mothers is common. The National Association of State Boards of Education (NASBE), in their survey of state policies related to adolescent parenthood, found that in all of the 46 states for which data were reported, some federal or state funds, or both, were available for services of some kind to pregnant and parenting teenagers, though which if any were available to special programs in LEAs was not known (NASBE, 1980).[14] The amount of state funding for local programs can be significant. One state funds 100 percent of program costs. Others fund as much as 3.5 times average daily attendance (ADA), or reimburse teacher salaries at a fairly high level (up to 70 percent).[15] In a number of these states, the monies are entitlement funds available through special education.[16] In other states, funds are made available through State Health or Social Services departments; in some states these funds are targeted on the basis of need.

In most cases state funds are tied to particular program features. For example, a local program may have to have a classroom component in order to receive extra funds from the Office of Physically Handicapped. Or, even if no funds are officially available to support programs for pregnant students or teenage mothers, local programs may receive teacher salary supplementation monies if these programs are classified under "Adult Education."

In a few states, an explicit program model is required. For example, one source of state funds limits eligibility to programs located in high schools that have a postnatal focus; a child care facility must be provided. Several states make Federal Title V funds available to support programs for pregnant students; one state uses Title V funds to provide seed money to local communities with the greatest needs to establish special programs for pregnant students and teenage mothers.[17]

State technical assistance seems a rarer commodity than funds. The National Association of State Boards of Education (NASBE) survey found that, in 19 of the 46 states for which data were available, no person is formally responsible for programs for pregnant students or teenage mothers. In 18 other states, less than one full-time-equivalent (FTE) was assigned to this area (NASBE, 1980). In several states with limited staffing, interested individuals have tried to improve state operations in this area by informally taking on this responsibility or by putting

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[14]The data were collected in a way that makes it impossible to determine whether school programs may receive funds from a given source and, if so, whether the funds are provided on a competitive or entitlement basis, as a matter of general policy, or on some other basis (Alexander, personal communication).

[15]States provide funds to school districts on the basis of average daily attendance or total attendance on a given count day. States may provide extra funds to local districts as an increment to the basic level of state support provided to each student to finance special programs or otherwise help defray the extra costs incurred in educating specified categories of students. These funds may come from the state's general fund, from federal sources, or from a combination of both.

[16]PL94-142, the Education for All Handicapped Children Act, did not include pregnant students. States could continue to classify pregnant students as handicapped and hence eligible for special state education funds, but stronger interest groups, e.g., the blind and deaf, have pushed for their exclusion. The trend is for states to remove pregnant students from the Special Education Category.

[17]Title V of the Social Security Act (Maternal and Child Health) provides formula grants to states for the extension and improvement of services for reducing infant mortality and morbidity and improvement of health of mothers and children, and provides special formula grants for maternity and infant care, intensive infant care services, and health care services for children.

LEAs with questions in touch with LEAs that have confronted and resolved that particular issue.

Lack of program models, outcome data, or adequate technical assistance has resulted in a substantive leadership vacuum at the state level. Although funds are often available, local planners must depend on their own resources to develop workable high-quality programs.

State policies concerning attendance and provision of services may also influence local efforts to meet the needs of pregnant and parenting students and retain them in school. Legislation in some states waives mandatory attendance requirements, which discourages retention efforts. In others, pregnant students and teenage mothers may be denied certain services, notably homebound instruction.[18]

### Local Level

Partly as a result of the limited presence of the federal and state governments in this area, school responses to student pregnancy and parenthood are heavily influenced by local school district policies, only some of which are explicitly directed to this group.

The most important of these policies express the district's commitment to retaining and educating as many students as possible.

### Concern About Dropouts

The treatment and fortunes of pregnant students and teenage mothers are influenced by the district's commitment to help *all* students complete school. A teenage mother who is not helped in any way to stay in school is a likely candidate for dropping out. The extent to which the district actively tries to prevent school dropouts affects the climate in which pregnant students and teenage mothers receive or do not receive help and support.

Most districts make only limited efforts to reduce the rate of dropouts, whether male or female, pregnant or not. Few make any effort to identify potential dropouts or to follow up on actual ones, particularly when they are over-age. In some districts, students who decide to leave simply announce the fact. No attempts are made to counsel the student concerning the effects of dropping out on future prospects, or to suggest alternative programs, including adult education and afternoon programs. Such inaction is discussed in a recent study of California dropouts (Camp, 1980). The report notes that schools may push students out, or external factors such as jobs may pull them out. The study concludes that "the more dominant force is the failure of the educational system to adequately gauge and provide early intervention for those students whose growing dissatisfaction with school culminates in their dropping out" (Camp, 1980, p. 18). Dropping out of school is frequently preceded by irregular attendance and truancy, which might be noted and followed up, but rarely are. A few LEAs conduct poor or no followups on dropouts because they are just as happy to see unmotivated students leave the system.

More commonly, efforts in this area are limited by the enormous costs involved in followup, particularly when the transiency rate is high. Such efforts are not very effective anyway. There are no levers when students are over-age, and few when they are not. Cases often drag on so long that a student *becomes* over-age by the time a case reaches court. And if the student is

[18]Complete denial of homebound instruction to pregnant and parenting students appears to violate both the letter and spirit of Title IX.

a mother, her case is usually dropped, even when state law requires attendance for teenage parents.

District policy may also discourage school-motivated dropouts from reentering. Several districts have informal policies that require entrants into the pregnancy program to transfer in from a regular school program. For dropouts, this means that they and their parents have to appear at and enroll in a regular school before being allowed to attend the special program. This policy discourages school reentry, particularly by those whose pregnancies have estranged them from their families, and furthers the districts' goal of excluding pregnant students.

### Flexibility

Parenting students benefit directly from flexible district policies concerning scheduling, awarding of diplomas, and enrollment in special programs that may make school continuation and completion more possible for both parenting and nonparenting students. A district may allow students to take courses during the summer or at night school and apply credits toward regular school graduation. Although adult school attendance often is formally restricted to those over 18, students over 16—and in some cases younger students as well—may be permitted to attend day adult school. This flexibility may enable teenage mothers with only part-time child care arrangements to attend afternoon and evening classes; nonparenting students can hold a full-time job and still continue regular high school coursework. A district can decide to award regular high school diplomas, generally considered more valuable than a General Education Degree (GED) or adult school diploma, upon completion of adult or other alternative programs.

Or, a district may interpret policies so rigidly that they impede school continuation. For example, one district's interpretation of a state law sometimes bars student parents from school. This law states that a student is entitled to 13 years of consecutive education. Students who drop out (often because of pregnancy and parenthood) and then seek reentry after some time has passed may be refused admittance under this policy if 13 years have passed since entry into the educational system. In another LEA, several unexcused absences result in disciplinary measures. Missing school because of a child's illness constitutes an unexcused absence. Hence parenting students are treated like truants under this policy.

## STUDY OBJECTIVES

Given the many constraints on an affirmative LEA response to student parenthood and pregnancy, the existence of any local program must be viewed as a major achievement. In the chapters that follow, we examine 12 programs in 11 districts, noting variations in local practice in response to the many constraints which exist at every point in the life of a program for pregnant students and teenage mothers. We also consider how the programs, as well as school policies and school attitudes, affect the decisions that pregnant students and teenage mothers make about pregnancy and their school careers. Our data collection was oriented toward three specific objectives:

1. *To understand how pregnant junior and senior high school students decide whether to drop out of school, or to continue in school without significant interruption, to marry, or to remain single.* To what extent do school factors, such as perceived importance of school completion to future goals and the strength of ties to school peers, affect these decisions?

2. *To assess the current role of schools in the decisions of pregnant and parenting students to continue in school.* School policies may influence these decisions in a number of ways. For example, if pregnant students can receive credit for work in progress and resume their studies post partum without loss of a full semester or year, the rate of school continuation may increase. If they are forced, despite Title IX, to leave regular classes and attend a "special" school, stigmatization and isolation from friends may precipitate school dropout. Does the school take an active or passive role with regard to pregnancy and school career decisions? What are the attitudes of school staff toward student pregnancy? How do they convey these attitudes?
3. *To determine whether there are exemplary programs, schools, or school districts that have been effective in serving the many needs of pregnant students and teenage mothers.*

To address these objectives, we conducted fieldwork in 9 school districts around the country. We then visited 2 other districts which sponsored programs we believed to be exemplary. This fieldwork, the procedures for which are described in App. A, was guided by three basic assumptions:

1. The response of the schools to student pregnancy and parenthood depends on both endogenous factors, such as pregnancy rate and the LEA's sense of social responsibility, and exogenous factors, such as availability of services in the community, community views on the appropriateness of school involvement in this issue, and the broader state and federal context.
2. Formal policies, such as a statement of nonexclusion or a comprehensive pregnancy program, represent only a part of the schools' response. Equally important are informal policies, including staff supportiveness and level of concern and the attitudes of other students.
3. Programs and services for pregnant students and teenage mothers, like most other educational changes, depend for their effectiveness on more than project characteristics. Institutional support, referral policies, and staff attributes are among the many factors that influence the extent to which a program in a given site will be viewed as effective in serving client needs.

## STUDY DESIGN

Our field studies consisted of observations and informal, open-ended interviews with staff in regular program high schools, junior high schools, and special programs, with school district administrators, with community activists, and with pregnant and parenting teenagers. The field studies were designed to explore and compare the approaches taken by school districts to student pregnancy and parenthood.[19]

Because there is no existing theory or analytic framework for investigating the schools' response to student pregnancy or parenthood, the fieldwork necessarily had an exploratory orientation. Although we sought a sample of school districts that varied in terms of region, urbanization, demographic characteristics, and political ethos, we cared most about a district's apparent potential to provide interesting data about the handling of student pregnancy and parenthood.

Since the fieldwork data were not to be supplemented, validated or integrated with quan-

[19]The school district was taken as the unit of analysis since many policies and programs are district-wide.

titative data, site selection was critical. Given the exploratory nature of the study, a statistical sampling procedure was ruled out. Instead, we drew a purposive sample designed to maximize both the breadth of our results and the amount we could learn from each site. (See App. A for a discussion of site selection procedures.)

The 11 LEAs in our sample were selected in three stages. In stage one, we selected and visited four state capitals and two LEAs in each of these states. In stage two, we selected two "exemplary" programs in two other states (state location was not a selection criterion in stage two). In stage three, we visited an additional LEA in a seventh state. (See App. A for further discussion of study design.) The 11 LEAs range in enrollment from over 200,000 to under 10,000. Each had established a formal program to serve pregnant students or teenage mothers; one district ran two very different programs. Yearly enrollment in these 12 programs ranged from a high of 350 to a low of 24, with the largest enrollments generally in the largest districts. The oldest program had been established in 1966, the newest in 1977. Table 1 summarizes the characteristics of the fieldwork sample.[20]

## SCOPE AND LIMITATIONS OF THE ANALYSIS

This report presents a descriptive summary and a synthesis of the 11 case studies written by site visitors. The findings presented here are those that appear most consistently and compellingly throughout our case studies, though findings unique to a particular site or program are often noted as such.

Two general limitations of the analysis should be made explicit. First, since the fieldwork was exploratory, the analysis attempts only to describe and interpret the processes that were common to the sites we visited. Given our nonrepresentative sample, we cannot presume to generalize our findings to all school districts, or even to all LEAs of a certain type.

A second limitation is related to the first. We have made no attempt to give equal reference to the case study material we gathered. Instead, the case study data used throughout the text to illustrate our findings are drawn from those sites and programs which we believed had the most to contribute to our understanding of how schools respond to student pregnancy and parenthood. Any attempt to tabulate or quantify our findings across the case studies, then, would incorrectly imply that all the case data had been given equal weight in the analysis.

## ORGANIZATION OF THE REPORT

Chapters 2, 3, 4, and 5 each deal with one or more of the major study objectives. Chapter 2 presents the programs we visited and describes their implementation; Chap. 3 describes three exemplary programs that serve pregnant students and teenage mothers; Chap. 4 examines the role of the regular school in implementing district-level and school-level pregnancy policies; and Chap. 5 presents the perspectives of pregnant and parenting teenagers on their pregnancies and the schools' involvement in them. Chapter 6 presents our conclusions and recommendations.

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[20]Because we assured our respondents complete anonymity, no identification of school districts or individual respondents will appear in this report.

Table 1

CHARACTERISTICS OF THE FIELDWORK SAMPLE

| Characteristic | Districts |
|---|---|
| *Characteristics of the 11 School Districts* | |
| Region | |
| Northeast | 3 |
| North Central | 5 |
| South | 2 |
| West | 1 |
| Student enrollment | |
| <10,000 | 2 |
| 10,000-24,999 | 3 |
| 25,000-49,999 | 3 |
| 50,000-100,000 | 2 |
| >100,000 | 1 |
| Years program has been operating[a] | |
| <5 years | 3 |
| 5-9 years | 5 |
| >10 years | 4 |
| *Characteristics of the 4 States* | |
| Region | |
| Northeast | 1 |
| North Central | 2 |
| South | 1 |
| West | 0 |
| Funds for special programs for pregnant students and teenage mothers:[b] | |
| Through specialized state program | 1 |
| Through special education | 2 |
| Through other state agency | 1 |
| None | 1 |

[a]Numbers sum to >11 because one district operated two programs, both of which we visited.

[b]Numbers sum to >4 because one state provided funds through 2 agencies.

## Chapter 2

# PROGRAMS FOR PREGNANT STUDENTS AND TEENAGE MOTHERS

Pregnant students and teenage mothers have many and varied needs. Some, such as education and job placement assistance, are no different from those of other adolescents, but some are unique, such as prenatal care, coursework in child development, and child care. Many of these needs are addressed by services present in most communities, but service locations and mode of delivery may reduce access to and use by pregnant students and teenage mothers. For example, health departments in almost every site we visited operate clinics that provide prenatal care at little or no cost. Services are often difficult to reach, however, and teenagers may feel uncomfortable in an "adult" facility. Respondents in one site noted that moving an adolescent primary care clinic into a high school building from a location across the street from the same school resulted in a substantial decrease in delay in seeking prenatal care and thereby diminished pregnancy complications.

Contraceptive counseling and devices were available in nearly every community, either through Planned Parenthood or another agency. These services are underused by sexually active teenagers, according to respondents in these agencies. Lack of awareness inhibits use in some cases; in some communities teenagers are embarrassed to be seen entering these agencies.

The Department of Social Services or its local equivalent generally provides services that pregnant students and teenage mothers may need, including assistance in locating affordable housing, counseling, and child care referrals. Other agencies and programs sponsored by the YWCA, Salvation Army, and church groups may provide services for teenage mothers, welfare mothers, or infants. In some cases, these programs provide mothers opportunities to study for a General Education Degree (GED) and may also provide recreation and child care. Residential facilities for pregnant teenagers are available in many communities.

The schools provide a large and varied curriculum, and offer courses that are highly relevant to young parents, such as family life education and child development. However, most of these courses devote only a small percentage of class-hours to topics of great and immediate concern to teenage parents, such as prenatal development and parenting. They rarely cover childbirth education or contraceptive use, and most of them reach only a small and select population; few males or college-bound female students enroll.

Given the many needs of pregnant students and teenage mothers, the availability of at least some relevant services in the community, and mixed community views about the appropriateness of school involvement in this area, school people are often unclear about what school responses may be needed, expected, and tolerated. Factors within the school context further contribute to this uncertainty.

As noted in Chap. 1, Title IX of the 1972 Education Amendments prohibited discrimination against pregnant or parenting students, but mandated no affirmative response. The 1964 Civil Rights Act and subsequent court rulings, however, have established a climate in which equal educational opportunity rather than equal treatment is the relevant criterion. Since pregnant

students and teenage mothers clearly have special needs, could they be said to enjoy equal educational opportunities if they received no special school services?

Within the schools, those who want to help often disagree among themselves about how much and what kind of school help is needed. Some feel strongly that in addition to the many needs noted above, pregnant students need isolation, nurturance, and protection in order to continue in school without significant interruption. Crowded hallways, stairs, and occasional violence, as well as the embarrassment suffered in remaining with peers, might overwhelm a pregnant student and precipitate school dropout. A special program that isolates and protects pregnant students while it meets other needs is viewed as an appropriate and necessary school response. These views and their implication—that a separate school program is needed—are consistent with the views of others that pregnant students do not belong in regular school.

Others argue that isolation is not the answer—that the appropriate school role is to refer pregnant and parenting students to services available elsewhere in the community, and to provide only those not otherwise available. These people believe that "mainstreaming" helps pregnant students to cope with the multiple roles of adolescent, student, and parent while allowing them to remain with friends and continue specialized coursework. Coursework such as parenting and child development can best be provided as electives; students can be helped to use existing community-based services to meet their other needs. These views win support from those who oppose the establishment of a separate program on cost grounds, and those who fear that a separate program would be inherently unequal.

These varied and often competing views, interacting with the many constraints discussed in Chap. 1, strongly influence the creation and form of school-sponsored programs. In this chapter we examine the 12 school-sponsored programs represented in our sample of LEAs, with an eye to understanding how the factors discussed above influenced their establishment, design, and operations.[1]

To facilitate discussion, we have grouped the 12 programs into three categories on the basis of their relationship to the regular school curriculum. These three categories are briefly defined below.

*Inclusive Curriculum Programs* offer enrollees a general education curriculum as well as a range of "relevant" coursework, such as parenting and child development classes. They may also offer services ranging from counseling and referral to health monitoring and child care. The unifying feature of these programs is that students who enroll in them do not attend regular classes.[2]

*Supplementary Curriculum Programs* provide "relevant" coursework for school credit to enrollees who are receiving general educational services in regular classes. These programs may also provide other services, such as child care or counseling. The key feature of these programs is that students who enroll in them attend regular classes for most of the day and receive school credit for program coursework.

*Noncurricular Programs* are not credit-granting, though they may provide a range of "relevant" instruction. Students enrolled in these programs may receive counseling, medical care, and referrals, but they receive no school credit for their studies in the program. Enrollees attend regular classes in most cases, though program services may also be available to those attending other school programs or to dropouts.

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[1]Since this was a study of school responses to adolescent pregnancy and parenthood, we do not analyze programs which are not at least partially school-sponsored, though we visited one or more in each site. However, community services and programs may influence the context in which school programs are established and are considered in this regard in the analysis of school-sponsored programs.

[2]A number of program heads noted that enrollees are permitted to attend regular classes, but differences in schedules and transportation problems mean that virtually no one does so.

The staff and supporters of the programs we visited share strong views that student pregnancy and parenthood and its prevention are necessarily school concerns. They most often cite dropout rates among pregnant students, and the prevalence of medical problems and child abuse among the children of teenage mothers, as reasons why schools cannot take a hands-off attitude. While most would like to see long-term care provided to pregnant students and teenage mothers, they diverge in their views about the critical phases of student pregnancy and parenthood. One group contends that the most vulnerable period is in the latter months of pregnancy when the pregnancy is visible and a student is likely to be exposed to embarrassment and stress. The period of pregnancy is also seen as critical in terms of medical outcomes: Proper nutrition and prenatal care may improve the outcomes for baby and mother. These people generally feel that special programs should focus on the pregnancy period. The other prevalent view is that although pregnancy may be a difficult time, the focus of school efforts should be on the postnatal period, when the mother must adapt to the new role of parent at the same time as she continues and necessarily modifies her adolescent/student role.

The way in which these views translate to program models in our sites is discussed in the next sections.

## PROGRAM MODELS

### Inclusive Curriculum Programs

The most prevalent program type is the inclusive curriculum program, which is common because it responds to institutional needs, the medical model, and the views of those who see school-age pregnancy as a trauma.

The seven inclusive curriculum programs we visited[3] are similar in being physically and in most cases administratively isolated from regular school. They may be under the supervision of the Director of Special Education, Handicapped or Homebound Instruction, or they may report to an Assistant Superintendent for Special Programs. In only two instances was the program under the same supervision as mainline academic programs; in one case the program had been transferred from Special Education because of administrative concerns about the poor academic quality of the program. This isolation is approved by school staff of all stripes; those hostile to pregnant students can remove them from regular school legally, while those most protective stress the advantages of the sheltered environment and homogeneous student body that a physically isolated program offers. For school administrators, the "problem" of student pregnancy seems to disappear when pregnant students transfer to the special program. To assist a pregnant student, regular school staff need know nothing more than the phone number of the program director. Said one regular school counselor, "When I'm confronted with a pregnancy I immediately call the program. They know what to do. We don't."

In all the inclusive curriculum programs we visited, the emphasis is clearly on the period of pregnancy.[4] Services and support focus on prenatal care and preparation for delivery and

[3]One site had two school programs, one of which was an inclusive curriculum program. We visited both special programs in this site.

[4]This prenatal focus continues a historical tradition, dating from the mid-nineteenth century, in which pregnant adolescents were removed from their normal environment to a residential facility where they received care and strong encouragement to relinquish their infants for adoption. Upon relinquishment, the young woman returned to a "normal" (child-free) life (Sedlak, 1980).

parenting. The prenatal emphasis is underscored by requirements in all but one that enrollees must leave the program soon after delivery, "soon" being defined either in terms of elapsed time (typically six weeks) or in terms of the school calendar (the start of the next marking period or term). One program director regretted that requirement, feeling that many enrollees were not ready to return to regular school so soon after delivery. However, she said, "We simply could not accommodate currently pregnant girls if we allowed mothers to remain in the program past that time." A program director whose program serves six LEAs noted that LEA return policies have an important influence on postnatal school return. While all the participating districts have a policy that requires school return at six weeks or the nearest marking period to this time, LEAs that are more flexible in allowing program-stay to be extended tend to have more program enrollees returning to regular school.

The prenatal emphasis in these programs reflects the overriding concern our respondents feel for the physical well-being of mother and fetus. Most school staff ranked a healthy mother and baby as the first goal of a special program; a minimally interrupted school career was ranked second.[5] The prenatal emphasis also reflects views held by many staff about the effects of a pregnancy on a teenager. People involved in and supportive of inclusive curriculum programs emphasize that pregnancy is a traumatic experience for young women whether they admit it or not. Because the pregnancy is a trauma, during this time the major needs are for support, protection, counseling, and "relevant" learning, e.g., child development. Academic learning, while important, should take a secondary role.[6] These views are reflected in program curricula. A high percentage of program time is devoted to prenatal, parenting, and other relevant classes (e.g., budgeting), work in the child care center, and counseling: at least a third and in one case 70 percent.[7] The secondary status of academic learning is also reflected in the quality of the academic component of these programs. Most were described as weak or poor in the level and quality of instruction provided. A few were regarded as remedial. In several LEAs counselors advised bright students to stay in regular school because the academic component of the program was so weak.

In all but one inclusive curriculum program, no services are provided past the immediate postnatal period, nor do other school programs or personnel provide such services in these LEAs. Students transfer out of the special program, presumably back into their regular schools, and become indistinguishable from the other students. Institutional needs, medical concerns, and the "pregnancy as trauma" viewpoint all dictate that continuing in a special program after delivery is less important.[8] Those who have delivered are not physically identifiable in the general student body, the baby has arrived, and the trauma is past. A few program directors regretted that no services are available in regular schools to mothers who have left their programs, and several noted efforts that students themselves had made to retain program ties, e.g., by entering the adult education program in the same building that houses the special program in preference to returning to regular school. But these directors felt impotent to help, citing restrictive LEA policies and the pressing needs of the currently pregnant.

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[5]Yet, in spite of the often voiced concern for initiating early prenatal care, no special program made an effort to elicit regular school staff cooperation in identifying early pregnancies. This reflects in part institutional needs to deny or at least not to seek out a "problem." See Chap. 4 for further discussion of pregnancy detection in regular schools.

[6]Proponents of this view note that since most enrollees stay in inclusive curriculum programs less than a full school year, the lack of academic emphasis is only a short-term one.

[7]Programs with the highest percentages tended to be part-day programs. They generally provided as much "relevant" learning as full-day programs, with time for academic programming necessarily reduced.

[8]Historically, programs for pregnant women ended at delivery because nearly all gave up their infants for adoption. In a period when very few teenagers relinquish their infants for adoption, adherence to this traditional prenatal focus may be less appropriate.

### Noninclusive Programs

Five of the 12 programs we visited do not follow the inclusive curriculum model. Two of these programs can be categorized as supplementary curriculum programs. Both provide parenting-related coursework for credit in lieu of other electives. Both programs provide child care; the child care center provides parents and nonparents a lab component to their parenting classes. Special services including counseling, health monitoring, and transportation are also provided. One program is supervised by the District Coordinator of Home Economics, the other by the Director of Pupil Services. Thus both are administratively separate from regular school. Unlike inclusive curriculum programs, however, their enrollees are not physically isolated. One program operates in a single high school site; students from other high schools are bused to the program. The second program operates in four district high schools; students in the other high schools do not receive program services.

Three programs we visited can be categorized as noncurricular.[9] One is a program of primary care medical clinics located in high schools. These clinics provide prenatal care and counseling as well as a full range of medical services for all school enrollees. The two other programs provide counseling and other services as needed; program counselors are responsible for coordination of needed services. One of these programs operates in six high schools. Program staff enlist regular faculty involvement in identifying and counseling pregnant and parenting students. The other program relies on staff counselors to deliver services. Program enrollees are often seen in their homes.

These programs are administratively separate from regular school. One is supervised by the Director of Pupil Services, one by the Coordinator of Social Work, and the third by the LEA Supervisor of School Health Services. Program enrollees generally attend regular classes on a full-time basis, though one program also provides services to those who are attending other education programs or have temporarily left school.

The founders of supplementary curriculum and noncurricular programs generally share the view that pregnancy among high school and junior high school students is a natural, even if somewhat precocious, event. Although prenatal care, parenting information, and counseling must be provided, the founders of noninclusive programs believe that it is not necessary to isolate pregnant students to do so. Supporters of these programs emphasize that while pregnancy and parenting are important, they must not overshadow other concerns, such as academic learning and social interaction, even for a short time. In their view, if students are to be successful teenage parents they must learn how to integrate the roles of student, teenager, and (prospective) parent. They can best learn these skills by remaining in the environment in which they will be a parent, the regular school.

If there is a trauma associated with teenage pregnancy and parenthood, the founders of noninclusive programs believe the trauma begins, not ends, at delivery. It is at this point that mothers need counseling, support, child development information, and often child care. They may need a flexible school schedule to accommodate a sick child, a shortened schoolday to accommodate limited child care arrangements, or temporary exemption from required physical education classes to accommodate embarrassment over a body not yet back in shape.

Program services reflect the beliefs of their founders and supporters that parenthood rather than pregnancy is the time of greatest need. All five noninclusive programs in our sample, as well as one inclusive curriculum program that allowed students to remain through graduation, provide a range of services to parents. In contrast, services to pregnant students are often not

[9]These three programs are presented in more detail in Chap. 3 as exemplary program models.

wholly oriented to their special needs. Only a few noninclusive programs, for example, provide childbirth instruction or monitor prenatal care, though noncurricular programs make referrals for these services. Typically, pregnant enrollees in supplementary curriculum programs simply participate in the parenting classes provided by the program. The need for isolation felt by some pregnant students obviously is not met by these mainstreaming programs.

Four of the six programs that provide long-term services for parents provide child care services; the other two actively help mothers to identify available child care arrangements in the community. Program staff everywhere agreed that child care is crucial in keeping mothers in school. Yet no one denied its high cost, or the fact that the dominant view in many communities is that child care is not an appropriate school activity. Program staff in one supplementary curriculum program described the difficulties they had in getting outside money to fund their center. They persisted because they believed child care to be crucial to school continuation. They noted that the previous school year (1978-79), with the center in place, 16 students used the nursery and the program, and attended regular school. In fall 1979, when foundation monies that had previously supported the center were not available and the child care center did not open, most of these 16 were not able to enroll in school.

Institutional needs are not ignored. The general view is that mainstreaming programs are far less expensive (relative program costs are discussed in some detail below). A number of respondents noted that the absence of a pregnancy program in a separate, identifiable building may contribute to the illusion that the problem does not exist.[10] Several respondents believe that having pregnant and parenting teenagers on campus makes parenting less glamorous and is a useful deterrent.

## FACTORS AFFECTING PROGRAM DESIGN AND OPERATION

Research on special projects (e.g., Greenwood, Mann, and McLaughlin, 1975) has shown that the ultimate character and effectiveness of new programs are significantly influenced by the way in which the programs are implemented. Implementation occurs in stages, beginning with initiation and moving through planning processes to implementation, outcomes, and longer-term stability. The outcome of each stage is strongly affected by factors in the institutional setting. In the pages that follow, the implementation of the 12 programs in our sample is discussed.

### Initiation

Program initiation is the first phase in the life of a special program. This phase is of special interest to state and federal policymakers. It is then that the decision whether or not to have a special program for pregnant students and parents may be influenced by federal and state law, policy, and financial incentives. We observed that local programs were initiated in response to a range of positive and negative incentives from the federal, state, and local levels.

Motivations for having special programs serving pregnant students and teenage mothers must be viewed against a context where opposing motivations are always strong. Such pro-

[10]In a similar vein, several respondents noted that inclusive curriculum programs in large urban LEAs rarely serve all those who wish to enroll because the numbers of enrollees would be so great. Two or more "pregnancy" schools might come to the attention of the community and cause problems for the district.

grams present the schools with a number of problems, several of which are common to all new programs:

- Dollar Cost. In a time of declining enrollment and inflation, the addition of costly new programs is regarded at best with hesitation. Few LEA administrators had a good sense of the marginal cost of the various program models, but all assumed *a priori* that any program will cost more than none at all.
- Administrative Costs. A special program requires special attention from administrators. Any program, but particularly a new one, may have problems that disrupt the system or at least create extra work for administrators. Said the director of one program, "An administrator's definition of program success . . . is above all that it present no problems."

Dollar and administrative costs may be factors that militate against establishing any new program. Programs for pregnant students and teenage mothers carry additional costs as well:

- "Creating" a Problem. The existence of a program indicates the existence of a problem. While administrators readily agree that ignoring problems does not make them go away, they note that the broader community often believes student pregnancy is a rare event until a program is developed to address it. When it is, communities are often shocked at its magnitude (although few programs serve even 50 percent of the eligible population) and often blame the schools for the problem.
- Negative Attitudes. Some school staff members as well as members of the community believe that student pregnancy and parenthood are not or should not be school concerns. Special programs may create resentment among people who believe that education monies should be spent on the "good" students.

In sum, fiscal and administrative obstacles constitute an important set of reasons why LEAs are not inclined to establish special programs. But there are others as well. The incentives to design and implement special programs are few to nonexistent.

The first step in implementing a special program is to generate support for it. Such support must eventually be found within the organizational setting, but may be generated by outside pressure. In most school districts no unitary outside interest group exists that could exert sufficient pressure for a special program. The parents of the already pregnant expect nothing and often are grateful for what services are available; the parents of the not (yet) pregnant do not believe their children might become pregnant and need special services. Few people in local school organizations are eager to assume the burden of developing and implementing a special program in the absence of strong incentives to do so. The tendency is for LEAs to do no more than comply with the nonexclusion of pregnant students required by law, especially since a district is as likely to be criticized as praised for establishing such a program. Given these negative motivations, then, it is rather surprising that many LEAs have created special programs.

LEAS may have some reasons to develop programs, however, including the legal and regulatory climate, institutional needs to provide services more cheaply, and client needs. Unlike the situation with some other special programs, the availability of outside funds generally does not influence the decision to initiate a program, though their availability may profoundly affect program structure, continuity, and ultimate success. This is true for several reasons. First, student pregnancy not being acceptable in most communities, a high pregnancy rate can be embarrassing to the school district, which therefore is motivated to hide the problem and any programmatic response from public view. In the absence of local need or outside pressure, funds would probably not be sufficient to motivate program initiation. Second, until

the establishment of the Office of Adolescent Pregnancy Program in 1978, there was no single source of categorical funds for these programs. A few programs have received ESEA Title I, Title III, and Title IV-C funds, but these sources often were not known or considered by our respondents, many of whom had no previous grantsmanship experience. While a number of states have provisions to fund substantial amounts of program costs (e.g., up to 80 percent of teacher salaries: an extra 2/3 ADA), local funds are still needed in most cases. And the common wisdom among educators is that these programs are always extremely costly, so that even with a state contribution, the LEA would have to bear a major cost.

Those programs in our sample that were developed in response to the requirements of law were located in conservative communities where local support in and out of school for any programmatic response to student parenthood was lacking. In these communities, no program existed prior to the passage of federal or state law that established the right of pregnant students to remain in school. Administrators in these districts saw only two legal responses to such statutes: permitting pregnant students to remain in regular classes or establishing a separate facility for them. As the first alternative was repugnant, the program decision seemed clear. In another LEA in a state with a nonexclusionary statute, passage of the law prompted program initiation as well. However, this LEA had already experimented with an inclusive curriculum program and had been forced to abandon it because of lack of LEA support, lack of transportation and resulting attendance problems. The response in this LEA was to create a limited noncurricular program. The programs we visited that were initiated in response to negative incentives were characterized by a lack of interest and commitment on the part of local participants (with the exception of the program head in one LEA). Compliance with the letter of the the law was deemed a sufficient response by most. As a result, program operations and outcomes were generally treated with indifference.

Several LEAs in our sample established an inclusive curriculum program for pregnant students as a means of reducing the scope of homebound instruction, which had grown larger and more costly each year.[11] LEA administrators contend that homebound instruction isolates students, provides minimal education, and disrupts their school attendance pattern, but the overriding motivation is cost. Programs initiated to reduce costs tend to be funded at a fairly low level by the LEA, and lack administrative support. In one case, the program remains administratively under the supervisor of homebound instruction. As a result, program staff are recruited from lists of homebound teachers, a significant weakness in the program. Program quality and outcomes continue to be compared with "how it was when there was only homebound"; as a result, LEA administrators regard these programs as highly successful. The many shortcomings of these programs in comparison with regular school program have been ignored.

Most of the programs we visited, however, were initiated primarily in response to client needs, usually defined in terms of high dropout rates among pregnant and parenting students. In about half of these cases, these needs were brought to the attention of the LEA by non-school groups. In one LEA, the State Department of Health approached the community because of its high rate of pregnancy. The policy in this state is to identify local communities which appear on the basis of vital statistics to need but do not have a program. Federal seed money is offered by this State Department of Health to begin a program. Local agency representatives, including

[11]Holmes, Klerman, and Gabrielson (1970) note that pregnant students are major users of homebound instruction. In one LEA without a special program, there were more applications for homebound instruction between 1965 and 1967 from pregnant students than from either male or nonpregnant female students. The percent of applications from pregnant students rose from 36 percent in school year 1965-66 to 47 percent in school year 1966-67.

school personnel, are brought together by the state coordinator and decide among themselves whether a program is needed, and if so, which community agency will sponsor it. In another site, a community group had begun a special program for pregnant and parenting students and lobbied the LEA to take it over. In all of these cases, the outside group found at least one sympathetic person in the LEA who took on the challenge of creating a program. In one of these LEAs, administrators promised a parents' group it would "look into" their concerns about a high dropout rate among teenage mothers from the local high school. However, they privately viewed the existing program (which was limited to the period of pregnancy and included pregnant with other "problem" students in a separate site) as a sufficient LEA response. A female administrator got wind of their resolve to do nothing and vowed to push for a program. Through force of will (and state funds that covered most program costs) she succeeded in establishing a supplementary curriculum program for student parents.

In the LEAs that had not experienced community pressures to initiate a program, one or more district staff members were instrumental in first identifying the need for special services for this group and then pushing for program implementation. In some cases, their efforts to conduct needs assessments were hindered by district administrators who did not want anyone to quantify the extent of the problem. In one LEA, a prevalence survey was allowed with the restriction that students could not be polled. In another LEA, survey plans were vetoed.

Districts were most likely to respond to demands for a program when the number of known pregnancies was high or when the LEA had a strong sense of social responsibility as defined by provision of other than strictly educational services, e.g., school lunch, breakfast programs, and after-school care.[12] Prevalence, defined in terms of total numbers of teenage pregnancies or high concentrations in certain schools, motivated a response in several LEAs in our sample.[13]

Districts in our sample characterized by a strong sense of social responsibility tend to have programs that are innovative in form and receive strong support from the superintendent. Superintendents in socially responsive LEAs often reported that LEA responsiveness to pregnancy as well as other needs is consistent with community views that the schools ought to do more than teach basic subjects. One exception to the pattern of association between LEA social responsiveness and high-level support for special program is the largest city in our sample. In this case, special program support from top administrators is minimal. They regard the pregnant student program as merely one of many special programs that have to be provided to their urban minority enrollment.

Community conservatism did not strongly influence program initiation, though it did influence program design, as discussed below.[14] Special programs were receiving at least some LEA support in some of the most conservative communities in our sample. One explanation

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[12]It is important to keep in mind that since we visited only LEAs with some program, we cannot make definitive statements about factors that may discriminate LEAs with and without programs. But we do have LEAs where program motivation was based on legal and fiscal concerns. These can be compared with programs motivated out of client need.

[13]The motivating force of prevalence helps to explain the tendency for large urban LEAs to offer programs while small or rural LEAs do not. Although teenage birth rates in rural areas are as high as or often higher than rates in nonrural areas, rural LEAs may be less likely to offer a program for three reasons. (1) Inclusive curriculum models, which are often considered to be synonymous with special programs, encounter practical difficulties when students are located at a distance from school sites and each other. Special buses may be required, and many students are unwilling to undertake rides of over an hour each way to attend school at a special site. (2) In many communities teenage pregnancy is still viewed as an exclusively urban minority phenomenon. Lack of awareness and acceptance of high pregnancy rates impedes establishment of special programs. (3) Although the pregnancy rate may be high, the absolute number of pregnancies (in the district as a whole or in any given school) is not. With only a few pregnancies at each school, the problem seems "ignorable."

[14]Community conservatism was indexed by support for liberal or conservative candidates, support for social welfare proposals, use of discretionary funds (e.g., parks or social programs), and climate of opinion about young people.

is that inclusive curriculum programs address community demands that pregnant students be excluded from regular school. A second explanation is that the programs are presented and seen as a service to babies, not to their mothers. Said one respondent, a local March of Dimes director, "The programs are presented and seen as having nothing to do with sex, and little to do with girls, who may be considered immoral. They're supported because they care for and help innocent little babies."

Other factors one might expect to be associated with concern for client needs, such as LEA financial status or innovativeness, were unrelated to program support in our sample. All but two LEAs in our sample reported themselves to be experiencing enrollment declines and bad to dismal financial situations; some of these have programs that receive heavy LEA financial support. The two LEAs in our sample that have growing enrollments and have experienced no cutbacks have minimal programs that receive little or no support from high-level administrators. None of the LEAs in our sample are highly innovative, as indexed by nature and number of new practices, or willingness to continue innovative programs begun with outside funds. But even with a truncated range on this dimension, level of LEA innovativeness was unrelated to program motivation or support. The reason for this lack of relationship may be explained by the prevailing view that these special programs have nothing to do with innovation. They are seen as a way to meet a special need, just as a gifted or remedial program might be.

### Program Design

Once a tentative understanding has been reached by or with LEA administrators that a program for pregnant students and teenage mothers should be established, a program must be designed and developed. One might expect LEAs, particularly those that are approaching program development as a means of meeting recognized local needs, to conduct a systematic search for program models or materials that have been designed or used elsewhere. But this search rarely took place among the LEAs in our sample. When it did, it was limited to nearby programs or to a program that planners had already decided to use as a model for their own. In some cases, the individual pushing for the program in the LEA had firm personal views about the most appropriate program type. In others, motivation for initiation determined the form a program would take.

In general, programs designed to reduce the costs of homebound instruction or to comply with nonexclusionary legislation took the form of inclusive curriculum programs. In the former case, an inclusive curriculum program simply "brought them all in." In the latter case, the legal requirement to include pregnant students in school programs and the LEA's desire to exclude them from regular classes led to adoption of this program model. In another LEA a very conservative community made an inclusive curriculum program the only feasible choice, both from the schools' and the students' perspective. "The community simply wouldn't have tolerated pregnant students in regular school," said the program head, "nor would pregnant students have been willing to stay."

Programs initiated in response to recognized local needs were freer of institutional constraints on their design and were more diverse in their ultimate form. Typically, the prime mover, who would be the program head, met with the superintendent to discuss program ideas.[15] She usually went into this meeting with a model already in mind, which reflected her

[15]No efforts were made in most sites to obtain imputs from regular school staff in designing the program; the superintendent-future director partnership was the norm. The relative isolation in which these special programs were established presaged the isolation in which most continue to exist years after their implementation. Though perhaps

own views of the most pressing needs and her assessment of the superintendent's commitment and the community's tolerance limit. The superintendent's support figured heavily in the formulation of the program design; his support in turn often depended on his reading of the community's likely reaction. In a few cases, the superintendent lent support despite anticipated community opposition.

Generally, strong superintendent support was associated with the establishment of more visible noninclusive programs. In conservative districts or in the absence of strong superintendent support, inclusive programs were more common.[16]

The availability and requirements of outside funding sources had little direct influence on program design. In only two cases did a program tailor its form to meet funding requirements. In one case, the program was housed in an adult school in order to qualify for state adult education funds. In another case a supplementary curriculum, parenting-oriented program had to be initiated in order to qualify for state funds. However, in this case the program director had been instrumental in lobbying for the state program; therefore her own philosophy was highly consistent with state funding requirements.

Outside funding sources influenced the administrative location of several programs, however. In several states funds are available to programs classified as "special education" programs. In these cases the program for pregnant students and teen mothers was so classified. An LEA's autonomy in these cases is limited; locating such a program anywhere *but* special education would cost essential funds. In other cases, however, an LEA may be free to designate a home for its special program. This choice may have an important influence on its autonomy, visibility, and financial prosperity.

In our sample, programs assigned to special education supervisors tend to receive little supervision. The special education director often noted that the demands of other special education programs are far greater. The fact that the pregnancy program has a very competent person on site directing a relatively small operation reduces the need for supervision. Most special program heads like the autonomy they have, and their complaints focus on special requirements (such as Individual Education Programs (IEPs)) associated with their "special education" designation. In a few cases, however, program heads were bitter about the lack of support they receive. One program head said that the only interaction she has with the special education director has to do with assuring the program's compliance with a maze of district, state, and federal special education requirements, most of which are irrelevant to pregnant students. Her requests for help on a funding proposal were ignored.

Two programs were supervised by the head of secondary instruction. In one district we visited, the inclusive curriculum program had been transferred from special education to secondary education out of concern for the quality of the programs' academic component. Most people felt this move was helpful in several ways. It forced the program head to talk to other teachers and principals, which spread the word about the program and its services. It helped her to understand the need for better academic training in the program to help new mothers make a smooth transition back to regular school. It also provided the program, now a "school," with a pot of discretionary funds to which each school in this district is entitled.

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not as open as a planning process should ideally be, these planning sessions were rational given the fact that in many cases the program was to be intentionally isolated from the mainstream of LEA activities.

[16]One program head noted that in a time of fiscal retrenchment the establishment of inclusive curriculum programs is unlikely. Holmes et al. (1970) note that placing together groups of students with similar problems, as inclusive curriculum programs do, may be only an intermediate step between homebound instruction and reincorporation. Hence several forces may be pushing districts inclined to develop any program toward noninclusive program models.

### Program Sponsorship

Of the 12 programs we visited, 10 were sponsored solely by the LEA. Two others were jointly sponsored by the schools and a local medical center; one of these was located on the hospital site. Such joint sponsorship seems desirable because provision of two major services—health and education—can thereby be assured. However, successful joint sponsorship seems to require more than shared commitment—a careful delineation of responsibilities based on expertise and ability and willingness to pay is required. One of the jointly sponsored programs we visited ran primary care clinics within high schools. The medical center ran the clinics and financed them with outside funds, while the school enrolled and taught pregnant, parent, and other clinic users in regular classes. While there was some overlap (e.g., clinic staff taught in some regular school health classes), each agency did its own job in its own area of expertise. As long as funding continued, the medical-center/school partnership seemed secure. The second jointly sponsored program, a hospital-based inclusive curriculum program, was not so well endowed financially. While the LEA provided teachers, the hospital financed the program director as well as the facilities and related costs. At the time of our visit, there was some feeling among hospital administrators that the hospital was using these funds inappropriately; there was pressure to divert program funds to the hiring of primary care nurses. Whether this program can continue may depend on a larger financial role by the schools.

This hospital-based program was benefitting in several ways from its location, however. As Klerman and Jekel (1973) note, a hospital provides an essential service, delivery, which may enable a hospital-based program to reach pregnant teenagers who may be less motivated to complete school. The director of this program had taken steps to learn of school-age patients who were coming to the hospital's prenatal clinic. She was sometimes successful in enrolling them in the program.

A hospital may also be seen as having a more legitimate role in pregnancy programs than do the schools. A number of respondents in our study noted that school health personnel who were employed by health agencies felt freer to work in this area because they were seen as medical rather than school personnel. Hospital employees in a hospital setting might feel even less constrained.

The two jointly sponsored programs were not the only instances of active interagency cooperation we found. In several LEA-sponsored programs, other agencies participated by assigning staff to the program on a full- or part-time basis. In one site a particularly active youth coordinator employed by the Department of Social Services worked closely with the program.

However, we saw only limited instances of strong informal communications networks among professionals in local agencies. More commonly, the LEA program was known but isolated. In no case did the school take on the role of lead agency in directing a community-based effort to control and respond to school-age pregnancy.[17]

### Seeking Funds

Once the idea of a special program for pregnant students and teenage mothers gained high-level district acceptance, its implementation was virtually assured. Although one future

[17]Allen and Bender (1980) note that the emergence of a seriously committed or lead agency is an important factor in a community's successful response to school-age pregnancy. Whether the schools would ever take such a role is questionable, given the many constraints on LEA involvement. The seed money policy used by one state in our sample to encourage local efforts to initiate programs would seem to be a promising strategy for encouraging community-wide recognition of the problem and the emergence of a lead agency.

program director was told that she could have a program only as long as it was funded wholly without LEA money, this was the exception. More commonly, an agreement was struck to have a program, and the prospective head then went to look for funds that allowed the agreed-upon model to be implemented with as much outside support as possible.

Most programs looked no farther than the state.[18] All but one of the seven states included in our purposive sample had some provision for funding of programs for pregnant students and teenage mothers, usually under special education. In two states, special funds for just such programs had been set aside.[19] A few programs received federal funds directly. A number of program directors cited the large amounts of paperwork and the lack of a clear categorical program as reasons for not seeking federal support. Others noted they had received no support or encouragement from LEA administrators to seek outside funds. Three program directors had applied for funds from the federal Office of Adolescent Pregnancy Programs (OAPP), a source of federal funds available only recently. Two of these three programs had previously received competitive funds from other federal agencies.

The general lack of grantsmanship among the programs in our sample reflects the noninnovative nature of these programs, the lack of grantsmanship experience among program planners, and the limited involvement of LEA grants personnel in these efforts. In our sample of 12 programs, only 4 had applied for and received other than entitlement funds. Only one of these was an inclusive curriculum program, and in this case the outside funds were provided by a local foundation concerned with prenatal and infant care.

## Planning

The period between the decision to have a program and its first implementation varied enormously. In one case, the program already existed in a church and would be changed only marginally by formal LEA sponsorship. On the other extreme, the implementation of a program that had already received substantial outside funds was delayed for over a year while the superintendent met with staff and community members in order to gain broad-based acceptance for its innovative approach.

Programs designed to meet recognized local needs tended to undergo a more intense planning process. These programs usually were able to articulate program goals, though frequently these goals, e.g., prevention of child abuse, were not measurable given the limited evaluation design envisioned. The supplementary curriculum programs devoted some planning time to recruitment of program sites. Several began operation with fewer sites than their planners had envisioned; staff hoped reluctant principals would agree to participate after the first sites were operating successfully.

In most LEAs virtually no planning time was spent working with regular school staff. Surprisingly, programs to be located in regular schools ignored regular staff as much as those to be located off-campus. No efforts were made to describe the program, its objectives, or how it might serve and relate to the needs of students and staff. This blind spot characterized most programs years after their initiation and seriously impaired their ability to provide continuing services to current and past enrollees. Few special program staff were even aware of the need

[18]States may provide support from the state's general fund, from federal sources, or from a combination of both. Since the state has discretion concerning the use of these funds, the decision to make them available to special programs serving pregnant or parenting students reflects a state commitment to this population.

[19]A number of states provide state special education funds for these programs. In several of these states, stronger special education constituencies, e.g., of the blind and deaf, are exerting pressure to exclude pregnant students from this category.

to actively enlist the support of regular school staff; in their view the services they provided spoke eloquently enough. Others who felt some efforts should be made to establish rapport were hampered by the opinion of high-level administrators that the more visible a pregnancy program is, the more likely it is to be vulnerable to the attacks of school staff and community members. In a few cases, professional jealousies caused initial efforts at communication to be rebuffed, as discussed in Chap. 4.

### Summary

Programs initiated in response to local needs, defined either by LEA staff or outsiders, were more likely to win support from the superintendent and other high-level administrators and were more likely to adopt an innovative program design. However, even when programs were initiated in response to client needs, LEA support was not assured. Yet administrative support is critical to the success of programs for several reasons.

First, special programs cost money. Even when outside funding is available, funding delays or changes in categorical program focus may require a program to fall back on the LEA for stopgap or longer-term funding.

Second, pregnancy programs compete in some sense with a number of other "special" programs for district resources such as space, equipment, and good will. High-level support for the program will help the flow of these resources.

Third, program founders want these programs to grow and change to meet enrollees' needs. A building and a staff are just a beginning; without continued district support, they may be the only things given gladly. Said the director of one program that received little LEA support, "They just let us exist. If the program were a priority, money would be found in the (LEA) budget for needed services. They'd also be more helpful in getting grants."

## PROGRAM IMPLEMENTATION

Once the decision is made to have a special program for pregnant and parenting students and a program model has been chosen, plans for the program must be translated into practice. Decisions about siting, staffing and equipping the program must be made. These decisions often reflect initial motivations for the program. In turn, they often profoundly affect program operations, quality, and outcomes.

### Program Site

Where a program is located has a major effect on who attends. Site and enrollee characteristics in turn influence how the program is viewed by both insiders and outsiders. Program siting decisions for the seven inclusive curriculum programs we visited were generally made by the superintendent or his deputy; rarely was the prospective program director included in these decisions. The decisions were generally made with the schools' needs in mind; programmatic implications were not considered.

In two LEAs, the superintendent decided that the program could not be located on school property because of strong opposition from the community and school staff. The LEA had, perhaps appropriately, little influence on where the program was housed in these cases. One

program was located in a building adjacent to the sponsoring medical center. The other program was located in a community center.

The other five inclusive curriculum programs were located on LEA property. With the exception of one Title I-funded program, which used these funds to construct housing for the program, the programs were located in schools that had been vacated because of enrollment decline, age, or in some cases, the requirements of a desegregation plan. These decisions obviously reflected LEA efforts to use space efficiently; in several cases they also reflected the program's low status and LEA motivation to limit awareness of the program. [20]

Every one of these five programs is located in a central city area. Some respondents believe that the inner-city location is appropriate and sometimes advantageous to potential enrollees, many of whom come from the central city and nearby areas. In one LEA, in fact, students attending the special program were the only minority students who were not bused under the LEA's desegregation plan. Other respondents decry these inner-city locations, arguing that student pregnancy is not strictly minority phenomenon, although inner-city sites may make it appear so.[21] In several cases, the special program site had been a minority school before it had been reassigned to the pregnancy program; the "minority" label stuck, and few nonminority students would enroll. In one LEA, the racial stereotype of the program is so strong that LEA staff actually have different informal policies for minority and nonminority students who become pregnant. Minority students from anywhere in the LEA are expected to transfer to the program; nonminority high school students are expected to drop out of school, while non-minority junior high school students are encouraged to get physician approval to remain out of school until after delivery. Two LEAs provide city bus tokens or transportation to the special program as a means of attracting a more racially heterogeneous enrollment; this policy has met with limited success.

In only two sites have any resources been devoted to improving program facilities, which were generally old and run-down. In one case, the non-LEA sponsor went to considerable expense to restore the building for program use. One LEA also did some upgrading; window air conditioners were installed (the other LEA high schools are air-conditioned), the institutional green walls were repainted with more cheerful colors, and the former boys' restrooms were "converted" by changing the sign on the door. None of these sites provide outdoor recreation areas comparable to regular school facilities—former playgrounds are now often parking lots.

Inner-city location has a positive aspect in the case of three programs. In these LEAs, the old school location provides the program with seemingly limitless space. This space allows for small-group and individual instruction, as well as a large child care center in one program.

Siting decisions for the five noninclusive programs seemed to be made with more concern for the location's programmatic implications. One reason may be that the easy alternative of an unused school was not available in these cases; another was that the program was to be far more visible. A third reason was that in nearly every case the noninclusive programs had more support from the superintendent; he ensured an advantageous location in several cases.

Because the noninclusive programs each have a site on a school campus, their facilities are generally no better or worse than the facilities for regular students. The noncurricular program that was a medical clinic, however, has particularly attractive and well-equipped facilities.

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[20]One LEA administrator noted that the community believed student pregnancy and parenthood to be strictly minority problems. Location of the program in an abandoned school in a minority area confirmed that belief and reduced the opposition that would have arisen had the program been located on the other side of town.

[21]Klerman (1979) notes that while the number of births to white teenagers far exceeds those to minorities, special programs serve largely minority populations. Our data suggest that inner-city location contributes to this phenomenon.

Care had been taken in one high school clinic to create a waiting room to be shared with the regular school nurse so that students would not be embarrassed to be seen there. One supplementary curriculum program that provides child care and parenting classes uses classrooms that were altered only sightly to accommodate the program. Nevertheless, the nursery is bright and cheerful. Only one noninclusive program, a noncurricular program that focuses on counseling, has facilities that appear to hinder its operations. Its program counseling facilities open directly out onto a busy outdoor walkway. Several respondents believe that this creates a privacy problem for potential users because anyone seen going in is assumed to be pregnant.

### Staff

A program's quality hinges on the skills and enthusiasm of its staff, a fact recognized by most programs in formulating staff recruitment policies. In 11 of the 12 programs we visited, the project director makes the hiring decisions.[22] In 7 of these 11 programs, the director is wholly responsible for the recruitment process as well. In a number of LEAs, program directors advertised widely, looking for potential staff members who were skilled in their subject area, flexible enough to be able to teach to a wide range of skills, and concerned about pregnant students and teenage mothers; directors did not expect to find staff with experience in working with pregnant students and teenage mothers, and few staff members had extensive experience. Recruitment efforts seemed to be effective: Staff in most programs seem sensitive and concerned as well as qualified in their subject area.

In a few programs, however, LEA policies hinder recruitment efforts. In one LEA, the director has no say in who teaches in her program. When she has an opening, a teacher is sent to fill it. Because of declining enrollment in the LEA, a new staff teacher is typically sent because she is no longer needed at her regular school but has tenure in the district. Until recently, male teachers were often sent to staff the program. After repeated requests from the director, this practice was stopped.[23] In another site, the program's administrative placement under home and hospital teaching requires that program teaching staff be recruited from substitute lists. Said the director of this program, "Some substitutes are subs because they lack the qualifications to be regular teachers. Others want to be homebound teachers because they don't want the responsibility of a classroom. Neither type is appropriate for a special program for pregnant students and teen mothers. This is one of the biggest weaknesses in our program."

### Equipment

The presence of needed equipment in good repair contributes to a productive learning environment. Lack of equipment may put pressures on staff to compensate by altering curricula or making do. In some cases, lack of equipment may mean that certain courses or experiences are not available.

Every inclusive curriculum program we visited claimed that their policy is to use the same texts an enrollee would be using had she continued in regular classes. When questioned more closely, it became clear that this policy is difficult to implement and often fails in practice. In most cases, programs are not assigned texts in the same manner that regular schools are,

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[22]Often the person had to be reviewed by the program's supervisor, but this review was generally pro forma.

[23]Not all program heads prefer an all-female staff. However, the point here is that directors need autonomy in making staffing decisions to maximize staff quality and enthusiasm.

although in several cases, this is the LEA policy. A number of directors described the extraordinary efforts that special program staff have to make merely to receive texts. Said one, "Everyone else's texts are just *there* when school starts. I have to call (downtown) at least four or five times before I get anything." One program tried to solve the problem by having students bring their books with them from regular school. The regular schools protested and the practice was stopped. Another program, administratively a school, was given a discretionary budget like every other school in the district. This money was to be spent on updating texts and buying workbooks and other materials. But the money was rarely available for these purposes. "Something always comes up that takes precedence," the program director said. Last year, for example, the state enforced for the first time a law long on the books that requires car seats for children being transported to school programs. Unable to obtain seats or money from manufacturers or foundations, the director had to use her discretionary funds for car seats or lose the child care center.

Other instructional equipment is even more difficult to obtain. We encountered only one program that has any science lab equipment, and this is minimal and outdated. As a result, no lab courses are available in any inclusive curriculum program. Most program staff regard this as only a minor inconvenience. They generally advise enrollees simply to delay lab courses until they return to regular school. A number also note that most program enrollees are not interested in such courses anyway. In some cases, however, lack of such equipment poses problems. In the one program we visited where enrollees may stay until high school graduation, lack of such equipment has a direct and detrimental effect on both learning and qualifying for postsecondary study. And even in short-term programs, a senior may need a lab course. In one program where this occurred, the science teacher taught nonlab chemistry to a prenursing student. The director believed in this case that the one-to-one relationship compensated for lack of lab experience. Similar comments were frequently made by special program staff.

Few inclusive curriculum program sites have library facilities, and none have language labs or facilities for fine arts pursuits (music, drama, dance, graphic arts). Physical education facilities are limited to exercise mats in the better equipped programs. In sum, the program sites generally provide a warm, accepting human environment but do not compare to the regular schools as a learning environment.

Specialized equipment, particularly nursery equipment, tend to be in better supply than instructional materials in both inclusive and supplementary curriculum programs. One reason may be that such materials contribute to child development and parenting coursework, which constitutes a major part of inclusive curriculum and the major activity of supplementary curriculum programs. Another may be that child care arrangements are not established until necessary equipment is assured—learning without texts may be difficult, but a nursery without cribs is impossible. Further, there may simply be more sources for specialized equipment. While texts come from the LEA in every case, March of Dimes and foundations contribute funds for equipment in several programs.

### Support for the Program

Support for a special program, particularly from high-level administrators, may be a program's most valuable resource. A program considered important by the superintendent is more likely to receive needed equipment and supplies, a sympathetic ear, and a hand over the rough spots. School districts can provide or withhold support in a variety of ways. An obvious source of support is district funds. Funds willingly given helped programs in a number of sites

to stabilize and grow. In others, lack of support or perhaps even worse, grudging, uncertain support contribute to low program staff morale and program instabilities.

The key to the presence or absence of financial support is the superintendent. Seemingly regardless of the LEA's financial situation, a supportive superintendent is a major factor in provision of direct support and grantsmanship skills. The superintendent can establish a positive orientation toward helping pregnant students and teenage mothers that trickles down and out. For example, strong superintendent support in several LEAs is associated with the active involvement of community agencies in a school-based program. Within the district, the superintendent's support seems to signal administrators that student pregnancy is to be taken seriously and actively dealt with. It was in the LEAs with silent or disapproving superintendents where we found the most discouraging practices. Some active involvement by the superintendent often is necessary to reinforce his or her verbal support. For example, in one district the inclusive curriculum program rarely receives what it asks for without a struggle, even when the requests are for items to which every student is entitled. The superintendent in the district reports he is concerned about pregnancy, but has delegated ultimate responsibility for the special program to an assistant. He acknowledged that ". . . there may be some administrators . . . who are opposed to . . . help for pregnant girls. I'm not sufficiently involved to be aware of this, much less to override them."

We witnessed the direct effects of superintendent support or lack of support in several programs. Two programs we visited support child care centers with funds made available by the welfare department to eligible mothers. These funds are paid on the basis of daily attendance. However, in both sites staff salaries must be paid regardless of how many children attend on a given day. As a result, a siege (or even a day) of bad weather or a flu epidemic plunges both child care centers into the red. In one LEA, the superintendent, who is very supportive of the program, has provided LEA funds to make up these deficits; in the other LEA, no district funds have been made available for this purpose. In the latter program, child care center deficits are made up out of the program's discretionary funds. These funds would normally be used for textbooks and other educational equipment.

One special program was weakened when the superintendent failed to appoint a new program head to replace the retiring director until a week before the start of school in the fall. Rumors that the program would end in June had demoralized staff and students for much of the previous year. The new head, on vacation at the time of her appointment, returned to her old job in the fall only to learn she had been reassigned. She had had no training for her new position and had lost the opportunity to work with the former director the year before. Although the program had recuperated by the time we visited it, it had been through a difficult time.

In another LEA a supportive superintendent has guaranteed a program that it will be continued (albeit at a reduced level) should it fail to receive the outside funds for which it has applied. This assurance has allayed considerable anxiety among program staff. In contrast, another program dependent on extramural funds that does not have strong LEA support has suffered complete staff turnover each year of its existence. Staff leave the program as soon as a regular secure teaching position becomes available, although several were said to have left the program with regret.

As important as administrative support may be in promoting a strong, innovative program, it may not be necessary for program survival. A number of programs we visited receive little such support but nevertheless are well run and stable. Often the administrative skills of the director keep the program going; some survive without even that. Lack of support may not be fatal because ultimately administrators want such programs to survive. They recognize that these programs are meeting institutional needs to serve—and exclude—pregnant students. If

the program were to fail, some enrollees would insist on attending regular classes. At the same time, the program is not popular and many resent its consumption of school funds. Therefore the program is assured continuity, but must struggle for excellence.

Among the programs we visited support from high-level LEA administrators is not common. In these cases program staff might be expected to try to gain support from other groups within and without the district. This is rarely attempted by the programs we visited. Only two of the inclusive curriculum programs receive active support from outside agencies (in the form of personnel being assigned to the program). Few have attempted to develop generalized community or agency backing. Noninclusive programs are more successful in this regard, as discussed below.

Several program directors said they make no attempts to elicit support because such efforts are likely to backfire. In their view, their respective programs have done as well as they have because of the low profile they had adopted, often at the suggestion of the superintendent. In one LEA a program that had adopted a very low profile has emerged from local obscurity in recent years because of its national recognition as a successful program—yet LEA support for this program remains low. The program director has not used the program's national acclaim to press for more LEA resources or other support.

For a number of reasons, noninclusive programs generally enjoy more high-level LEA support. One important reason is that these programs are usually established to meet local needs, and not to push student pregnancy and parenthood out of sight. By their nature, they could not be low profile programs. The superintendent had to be sufficiently committed to become a target of possible staff and community opposition. However, in several noninclusive programs we visited, steps had been taken to minimize opposition. For example, in one LEA, the district supervisor of the program had warned site directors to keep a low profile. In her view, the less noticeable such a program is, the better. In at least one school site, however, the program's low profile is unnecessary and unproductive. The building principal approved the program's coming into his school and in fact he is highly supportive of the program, and had allocated some building-level discretionary funds for program use. Yet the site director avoids contact with him, and has not asked for several things she might well have received.

The school board in most districts has had little to no involvement in the issue of student pregnancy and parenthood or in the special program. Most board members believe involvement in this issue would be troublesome for the board and, by making the issue more public, troublesome for the program as well. In only two LEAs has the board been actively involved in the program: In one LEA the board set up a number of restrictions on program costs and operations that had to be met in order to win board approval for program initiation; in the other, some board members publicly support the program. In most of the other districts, the school board limits its involvement to approval of proposals for extramural funds, or (in two cases) approval of a change in location. In three LEAs, the program bypassed board consideration entirely.

Lack of board involvement with special programs reflects a more generalized board motive to avoid the issue of student pregnancy and parenthood. Only two school boards have established formal policy on this issue.[24] Several have avoided doing so because a special policy would make the whole issue more salient. In other LEAs, inaction reflects lack of a strong constituency for special programs. One board member noted that mandatory desegregation and

[24]In both these LEAs, board policy guarantees pregnant students access to some schooling during pregnancy and specifies procedures for dealing with pregnancy. These policy statements conform closely with state law. A third LEA had established a policy but had not sought or received board approval for it.

the requirements of PL94-142 were demanding most of the board's time and energy. "Since no one out there is pressuring us (for more services for pregnant students and teen mothers), we just haven't dealt seriously with this issue."

Established groups, such as the March of Dimes, Planned Parenthood, and health providers, can generally be counted upon to support special programs; however, they tend to concern themselves with specific aspects of the needs of pregnant students and teenage mothers. Often they are not familiar enough with school operations to be aware of instances where special programs may be shortchanged. As noted above, program directors rarely come to them for help in gaining more resources from their LEAs. Contacts are usually limited to requests for in-kind services or small donations.

Increasing media concern with teenage pregnancy and parenthood has been helpful to several programs in gaining community support. Although these articles and programs usually emphasize the problem rather than discuss solutions, they tend to increase awareness of the special program and generate new support among sympathetic segments of the community.

In a number of states, advocacy groups have been and are active in lobbying for new legislation and revision of legislation already on the books. A prime target in several states is repeal of a law that waives mandatory attendance requirements for pregnant students and teenage mothers under age 16. However, the presence and strength of advocacy groups does not appear to have a consistent effect on local program quality or level of district support. Variation across programs within states is substantial.

## COSTS

Special programs that provide services to pregnant students and teenage mothers that are not available to other students, or that provide similar services in a more intensive way (e.g., a lower pupil/teacher ratio in academic courses), necessarily cost more than providing no special services at all.[25]

Most of the respondents to our study assume that such costs are enormous, and that even with outside funds, the district's contribution to these programs would be substantial. In our telephone survey of school staff in 14 LEAs early in the project, cost was often cited as a reason that a given district did not have a special program. Many respondents considered only inclusive curriculum programs in their discussion of costs, and assumed that those costs are exorbitant.

During our visits to the 12 programs in our sample, we collected necessary data for a limited analysis of special program costs. This analysis focused on three major questions: (1) How much do special programs cost? (2) How much more does it cost to educate a student who receives special services from a pregnancy or parenting program than it does to educate a student who receives no extra services? (3) What percentage of total program costs are covered by outside (non-LEA) sources of funds?

Table 2 presents the results. Column 1 indicates a substantial range in annual expenditures per pupil. Not surprisingly, inclusive curriculum programs generally cost more than supplementary curriculum and noncurricular programs. A substantial part of these costs is explained by the far lower pupil/teacher ratios in the academic component of the inclusive curriculum programs than in regular high school classrooms. The average pupil/teacher ratio

[25]One program head noted that special programs often use volunteers as a way of reducing costs. Nevertheless, the ratio of paid personnel to enrollees is higher in these programs than in regular classrooms, which increases costs.

## Table 2

### Total Program Expenditures Per Enrollee in School Year 1979-80

| Special Programs | (1) Annual Special Program Expenditures Per Pupil in Yearly Enrollment[a] | (2) Total Cost Ratio[b] | (3) District Cost Ratio[c] |
|---|---|---|---|
| Inclusive Curriculum Programs | | | |
| A | $1,880.42 | 2.90 | 1.39 |
| B | 1,408.80 | 2.07 | 0.91 |
| C | 822.20 | 1.80 | 1.24 |
| D | 436.33 | 1.19 | 0.86 |
| E | 644.23 | 1.64 | 0.51 |
| F | 1,744.20 | 2.47 | 2.28 |
| G | 7,102.88 | 9.29 | 1.86 |
| Supplementary Curriculum Programs | | | |
| H | 777.49 | 1.77 | 1.38 |
| I | 393.24 | 1.41 | 1.14 |
| Noncurricular Programs | | | |
| J | 96.83 | 1.12 | 1.09 |
| K | 1,312.50 | 2.73 | 1.00 |
| L | 21.60[d] | | |

[a] Entries represent the total amount spent per enrollee by the special program. Expenditures for special students while they are attending regular classes (either part-day or part-year) are excluded.

[b] Entries indicate the ratio of annual per pupil expenditures for special program enrollees to that for regular program students. An entry of 1.0 would mean that total expenditures are identical for both groups; entries greater than 1.0 indicate that expenditures are greater for special program than for regular program enrollees. These calculations take into account the fact that most special program enrollees do not spend a full school year in the program. Therefore the numerator of this ratio includes expenditures in both regular and special programs.

[c] Entries indicate the ratio of annual unreimbursed per pupil expenditures for special program enrollees to expenditures for regular program students. Entries less than 1.0 indicate that the district spends less for special program enrollees than for regular students. These calculations take into account the fact that most special program enrollees do not spend a full school year in the program. (See App. B for discussion of analysis methods.)

[d] The average cost per clinic visit. The number of visits made varies widely, depending on several factors including how early prenatal care begins, how many appointments are kept, and whether the student attends prenatal and parenting classes. Additionally, cost calculations require data concerning length of visit by visit type. Collection of these data was beyond the scope of this project.

in the seven inclusive curriculum programs we visited is less than 13/1, with the ratio in one program less than 4/1. Additionally, every inclusive curriculum program has at least one on-site administrator, whether enrollment is 350 or as little as 25.

As shown in column 2 of Table 2, the total annual expenditures per special program enrollee (which includes time spent in the regular program) range from 1.12 to 2.90 times the total annual expenditures per regular pupil, with the exception of the one outlier program with a very high staff-to-student ratio. The supplementary curriculum programs have the lowest mean total cost ratio, even when Program G is excluded from the calculation of the mean total cost ratio for inclusive curriculum programs. This finding makes sense since supplementary curriculum programs replace only a small part of the school day, and provide only those services not available in regular classes. In contrast, inclusive curriculum programs replace the entire regular school program, while noncurricular programs provide services in addition to the full-time regular school program.

The programs in our sample generally are quite successful in securing outside funds to support program operations. Outside funds cover from 21 percent to 121 percent of total special program expenditures, with the mean contribution equal to 63 percent of total special program expenditures. These outside funds reduce the amounts LEAs must expend from their own funds for special programs. Consequently, the ratio of total annual unreimbursed expenditures per special pupil to total annual expenditures per regular pupil (District Cost Ratio) is often far lower than the total cost ratio in column 2. These ratios ranged from a low of 0.51, indicating that the district is benefiting financially from the program, to a high of 2.28.

The expenditure analyses indicate that special programs for pregnant and parenting students do cost more than educating them without special services. In our sample the average total cost ratio was 2.60. However, the programs in our sample, which was biased toward successful programs, were able to cover on average more than half of these costs with outside funds. Consequently, the district cost ratio averaged only 1.24. These ratios are not excessively high considering that many special services are provided.[26] It is also important to remember that the average enrollee remains in a special program for only a short time, often less than one school year, unlike programs for the handicapped, in which excess costs are often incurred year after year for each student.

The data suggest that these programs need not pose a major financial burden on a sponsoring LEA. Receipt of state entitlement funds, in-kind services from community agencies, and perhaps some federal grant monies, may enable a district to initiate a program without taking on a major financial burden. Selection of a noninclusive program model would seem to be a way to limit an LEA's financial commitment.

At the same time, the outside funds received by programs in our sample are far from secure in many cases. State level lobbying by strong special education constituencies may reduce or eliminate state special education funding for pregnancy programs in the future. Transfer of federal funds into bloc grants may also diminish funds for special programs. Local funds are becoming more constrained as well, because of fiscal retrenchment. In this fiscal climate, efforts to secure stable funding for special programs take on added significance.

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[26]These services may have long-term effects such as delayed subsequent pregnancy and school continuation that will reduce welfare and personal costs in the long term. (See "Effects on Enrollees," below.)

## Program Operations

Programs varied considerably in schedules, format, and services provided. In the sections below, these program operations are detailed.

**Program Services.** As shown in Table 3, the inclusive curriculum programs provide far more services than the noninclusive programs, in part because they supply enrollees with educational services that regular schools provide to enrollees of supplementary curriculum and noncurricular programs. They also supply more services because they subscribe to the notion of "pregnancy as trauma." This idea dictates the provision of a separate nurturing environment in which those who may be in crisis and therefore unable to function effectively in the larger community can be provided continuing support and needed services.

All but one of the seven inclusive curriculum programs we visited provide formal counseling; one of the two supplementary curriculum programs and all three noncurricular programs do so as well. Staff in the two programs that do not provide formal counseling discuss personal difficulties as they arise and see such discussion as part of the program's services.

All inclusive and supplementary curriculum programs provide coursework in parenting, child development, and child care as do two of the noncurricular programs. Programs with child care components use the nursery to provide lab experience for enrollees. Supplementary curriculum programs with child care provide these lab experiences to nonparents as well.

Several programs provide a prenatal curriculum that focuses on fetal development, nutrition during pregnancy, and delivery. Several include Lamaze instruction and exercises in this curriculum (prenatal exercises when available are the only physical education opportunity offered in special programs).

Nine programs had the services of one or more nurses, who typically teach prenatal and health units and keep health charts on mothers (and, when child care is available, on babies). They monitor clinic attendance and compliance with prescribed regimens or diets. No program except the high school clinics provides primary health care.

Consistent with the shared goal of reducing the incidence of subsequent teenage pregnancies, most programs provide birth control information and spend time discussing sexual relationships and the option to abstain from sex. But such information is often provided informally and presented as an afterthought, although most program staff regard a reduction in subsequent teenage births as an indicator of program quality. This is particularly true in the inclusive curriculum programs, where health concerns focus strongly on the current pregnancy and delivery. The programs that enroll students for a substantial time after delivery or are exclusively parenting programs appear to present this information more forcefully.[27]

All inclusive curriculum programs provide lunch, and four provide breakfast or snacks as well. The four programs with nurseries provide food for babies. Five programs provide transportation, although in one case only between the enrollees' home school and the program site in the other high school. Two programs provide enrollees with city bus passes.

Six of the seven inclusive curriculum programs provide career counseling or vocational education coursework. In three of these programs, career preparation is limited to coursework in shorthand and typing; in a fourth program, the vocational education program includes filmstrips on careers. Advanced business machines are not available in any program, although at the time of our visits individual students in two programs were taking vocational education

[27]Most programs offer information about and access to birth control devices along with encouragement to delay future pregnancies for the sake of the child about to be or just born. Only one, the clinic program, monitors birth control compliance on a continuing basis. These efforts are facilitated by the clinic's in-school location and the program's commitment to continuing care.

## Table 3

### Services Provided by Special Programs

*A. Coursework*

| Program | English | Math | Social Science | Lab Science | Foreign Language | Vocational Education | Art/ Music | Health/ Nutrition | Parenting, Child Development | Prenatal | Life Skills |
|---|---|---|---|---|---|---|---|---|---|---|---|
| *Inclusive Curriculum Programs* | | | | | | | | | | | |
| A | X | X | | | | X[a] | | X | X | | X |
| B | X | X | X | | | X | | X | X | X | |
| C | X | X | X | | | X[a] | | X | X | | X |
| D | X | X | X | X | | X[b] | | X | X | X | |
| E | X | X | X | | | X | X | | X | X | |
| F | X | X | X | X | | X[a] | | X | X | | |
| G | X | X | X | X | | | | X | X | X | X |
| *Supplementary Curriculum Programs* | | | | | | | | | | | |
| H | | | | | | | | | X | X | X |
| I | | | | | | | | | X | | X |
| *Noncurricular Programs* | | | | | | | | | | | |
| J | | | | | | | | | X | | |
| K | | | | | | | | | X | X | |
| L | | | | | | | | | | X | X |

*B. Services*

| Program | Counseling | Exercise | Child Care | Health Monitoring | Transportation | Breakfast/ Snacks | Job Placement | Library |
|---|---|---|---|---|---|---|---|---|
| *Inclusive Curriculum Programs* | | | | | | | | |
| A | X | X | X | X | X | | | X |
| B | X | | | X | X | | | |
| C | X | | | X | free bus tokens | X | | |
| D | X | X | | X | free bus passes | | | |
| E | X | | X | X | X | X | X | |
| F | | X | | X | X | | | |
| G | X | X | | X | | X | | |
| *Supplementary Curriculum Programs* | | | | | | | | |
| H | | | X | X | X | X | | |
| I | X | | X | | | | | |
| *Noncurricular Programs* | | | | | | | | |
| J | X | | | | | | | |
| K | X | | | | | | | |
| L | X | | X | X | | | | |

NOTE: Services described are regularly provided. Many programs provide special courses (e.g., foreign language, journalism) on an as-needed basis.

[a] Limited to business courses (typing, shorthand).

[b] Limited to filmstrips on careers.

courses through adult schools that share the program site.[28] No program tries explicitly to help enrollees reconcile their need to earn money in the short term with longer-term needs to train for meaningful work.

Although nearly every program director believes that provision of on-site child care is critical for keeping mothers in school, only four of the 12 programs provide this service. Most cited the enormous costs of child care services as the major barrier; and several directors noted that large segments of their communities are strongly opposed to school involvement in the provision of such a service. Each of the programs in our sample that provide child care supported it with non-LEA funds.[29]

**Program Schedule.** All inclusive curriculum programs run for the full school year. Four of the seven we visited operate full school days. Three others operate four or five hours daily. The directors of the part-time programs listed several advantages in running less than a full day, including reduced disruption from clinic appointments that can be scheduled outside of class hours, and more time for students to rest each day. Regular school staff noted that a part-day schedule makes the inclusive curriculum program more attractive than regular school to less motivated students, and may help to keep some from dropping out.

Each of the three part-day programs receives low levels of superintendent support. Although the fact was not discussed, a part-time program is less expensive to run. This factor may have influenced scheduling decisions.

At least one "full-day" program is actually a part-time program, although in this instance the reduced teaching time is a policy decision made by the director. In this program, one day a week is set aside for outside speakers, field trips, and catching up on school work. Several enrollees in this program told us they appreciate the "catch up" days which enable them to do more homework than they had ever done in regular school.

Though specific schedules vary, most programs have a daily schedule of classes that includes one class period for each academic subject and child development/parenting. To the extent possible, subject area specialists teach appropriate classes. Other subjects, e.g., crafts, cooking, are taught less frequently if at all.

Some of the larger programs assign enrollees to classes roughly on the basis of grade levels in order to follow the regular school curriculum as closely as possible. Because of large variations in age and skill level, however, every program offers individualized instruction within classes. Several directors noted that this approach has worked well for some time, but that they are increasingly concerned about how well this approach would work in the future since the mean age of enrollees is declining and the age range in programs is increasing dramatically. They noted that few teachers are able to teach effectively the whole high school age group; teaching junior high school pupils and some elementary school students as well might be almost impossible. Only one program in our sample has attempted to actively deal with the "junior high problem." Its director hired one junior high teacher who teaches a self-contained junior high class while the high school enrollees are taught by subject specialists. This solution, which was possible because of a large yearly enrollment (about 300), has its own problems, notably that a qualified "generalist" must be found. Her knowledge in each subject area would necessarily be more superficial.

The limited curriculum in every inclusive curriculum program, and the reduced teaching

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[28]In one site this option seems available in fact only to unusually bright or motivated enrollees.

[29]In two programs, money is provided out of Title XX Social Security Act to local social services departments. These departments provide funds to the child care center for welfare-eligible mothers. In the third program, state funds pay child care costs. The fourth program depends on foundation funds, which are committed on a short-term basis.

hours in some, were defended on the grounds that students receive far more individual attention than is possible in regular classes. In support of their contention, program staff often pointed to the fact that the grades of most enrollees improve in the program. In rebuttal, regular school staff in several LEAs pointed to these improved grades as evidence that the program's academic curriculum is easier and the staff less demanding. The fact that enrollees virtually never fail courses in most of these programs was advanced by regular school faculty as evidence for the "coddling" view. Regular school faculty in several districts in our sample are sufficiently unhappy about the academic quality of the inclusive curriculum program that they encourage bright and ambitious students not to transfer. Program staff and students generally agree it is unusual for an enrollee to fail. Failure usually only occurs when attendance is very poor.[30]

In some contrast, regular school faculty and other respondents spoke with strong approval of the child development and parenting courses offered by special programs. Several of them do indeed seem exemplary. Their focus on applicable learning and realistic expectations for children was designed to meet the needs of soon-to-be parents; they appear to be doing so. During interviews with Rand staff, many teenage respondents discussed at some length the things they learned in parenting classes and how they would or did apply to their own parenting experiences. Part of the reason parenting courses won approval was that there was nothing to directly compare them with in most cases. Regular school courses that cover similar subjects are far less intensive and practically oriented. More important, however, is their relevance: Program and regular school staff frequently noted that the teaching of parenting skills is a major responsibility of special programs. Program directors regard these courses as the most important aspect of their programs. This feeling was reflected in the commitment of time and resources. As noted above, a substantial amount of class time is devoted to these courses. These courses are also better equipped than any others.

Attendance in special programs is generally poor, with the worst attendance problems in inclusive curriculum programs. In one program, as many as 50 percent of the enrollees might not come on a given day; however, some of them are out for delivery or are receiving postdelivery homebound instruction. Most program directors believe that poor attendance in their programs is simply a carryover of earlier attendance problems, not a situation unique to pregnancy. Some support for this view can be found in the variation in attendance patterns across programs. Programs that tend to attract good students have better aggregate attendance figures than do programs that attract more remedial students. This explanation squares with the better attendance patterns in supplementary curriculum programs: More academically motivated students tend to stay in school, while poor students with poor attendance are more likely to transfer. Programs with waiting lists also have better attendance; students are warned they will not be continued in the program if they do not attend regularly. Program directors feel justified in instituting this policy since the place might go to a more motivated student.

A few programs use the "carrot" approach to improving attendance by providing door-to-door transportation to enrollees. Most believe that this service is very useful in improving attendance.

**Enrollee Characteristics.** Special programs appeal to different types of students, depending on a range of program factors. In general, inclusive curriculum programs appeal to those less academically oriented. These students attach lower value to the academic offerings of regular programs and are motivated by the parenting-related coursework, the reduced competi-

[30]Several program directors noted that the relative lack of emphasis on academic coursework is particularly helpful to nonacademically oriented students who might drop out if this component were heavily stressed. As it is, they often stay in the program and benefit greatly from the relevant coursework provided.

tiveness, the friendlier atmosphere, and the often shorter hours of inclusive curriculum programs. As discussed above, siting may influence enrollee decisions; programs located in minority areas tend to have predominantly minority enrollments. Efforts to integrate the student body in these programs are rarely successful. In more than one of these LEAs, nonminority students drop out of school rather than attend a program that has been labeled "minority."

Community and school attitudes about student pregnancy and parenthood may also influence students' transfer decisions. In one site we visited, the inclusive curriculum program enrollment is predominantly middle class and academically motivated. In this community, students do not feel free to remain in regular school during pregnancy. Family pressures and personal motivation rule out even temporary school withdrawal.

Overall, however, embarrassment about a pregnancy had less effect on enrollees' decisions concerning school programs than we expected. In the one LEA we visited where both an in-school and an inclusive curriculum program are available, students who chose to transfer to the inclusive curriculum program cited program features as the major reason; those who enrolled in the noncurricular program were attracted by the opportunity to stay with friends and continue their education uninterrupted. (See Chap. 5 for further discussion of the factors that pregnant students and teenage mothers consider in making program decisions.)

Enrollment in supplementary curriculum and noncurricular programs depends on a set of different factors. A primary factor is academic motivation. These programs allow enrollees to continue their normal educational progress while being exposed to "relevant" learning. They also provide a way to remain among friends. A second factor affecting enrollment in on-campus programs is program features. For example, one program we visited focuses on the postnatal period and provides parenting coursework tied to child care. Students often enroll in this program because they need child care; relevant coursework is a bonus.

A substantial percentage of eligible students do not enroll in an available special program. In the case of inclusive curriculum programs, distance is an often-cited reason. Supplementary curriculum programs pose different, often more complex, barriers. These programs are established in regular schools only with the approval of the principal. Some principals are not willing to have the program in their building. Pregnant students and teenage mothers attending such schools do not receive program services, even though their districts "have a program." In other cases, principals are willing, but small numbers of eligible students may make program sites in each school very costly, particularly if child care is involved. The logistics involved in transporting enrollees from nonprogram schools to the school that houses the program can be complex and may result in a decrease in enrollment among those who would be transported. For example, in one LEA the supplementary curriculum program is located in one of the two district high schools. Students from the other high school bring their babies to the child care center in the program high school, then are bussed to their own high school for a morning of academic coursework. During lunch period they are bussed back to the program high school for parenting classes in the afternoon. No transportation is available to junior high school students; in order to participate in the program, they must attend a special secondary alternative school with "problem" students in the morning. These complex arrangements decrease participation among students from nonprogram schools; strong intramural competition between the two high schools further reduces enrollment from the nonprogram high school.

Overall, estimates of the percentage of those eligible who attend any special program range from 20 to 90 percent.[31] Program philosophy may strongly influence this figure. Some programs

[31]These figures can be only rough estimates because no data were available in any district on the number of student pregnancies, or the number carried to term. Most LEA administrators noted how difficult it would be to collect accurate

have chosen to provide intensive services to a small number of students; these programs often have waiting lists and may serve a low percentage of the eligible population. Other programs, such as supplementary curriculum programs oriented to parenting and child care, may serve low percentages of eligible teenagers because students may not need (or think they need) the services they provide. A few noncurricular programs have taken as their goal the provision of services to the universe of those eligible. These programs tend to have the most flexible features (i.e., counseling and referral) so that indeed almost anyone might find some assistance.

## PROGRAM OUTCOMES

Special programs can succeed or fail in a number of different ways. Programs may directly affect enrollees by promoting school continuation and graduation, reducing the likelihood of subsequent teenage pregnancies, increasing self-esteem, and promoting career ambitions. These effects may be long-term or short-term. Special programs may also have system effects. Program staff may be effective or not in increasing awareness and concern for the long-term needs of parenting students among LEA administrators and staff and members of the larger community.

Finally, programs may be successful or not in engendering their own stability. This stability may be achieved by securing a dependable outside funding source or by gaining sufficient support from LEA administrators that the program is accorded a secure status in the district.

### Effects on Enrollees

All the programs we visited, regardless of how long a student might be enrolled, hope to have long-term effects on enrollees. Program staff typically cited school completion and delay of subsequent adolescent pregnancies as long-term program goals; a few also cited absence of child abuse and pursuit of postsecondary education as desired long-term outcomes. Shorter-term objectives were generally less clearly defined. School continuation was seen as necessary to school completion, but other long-term goals often were not translated into shorter-term objectives. While all but a few programs collect some evaluation data, only one collects data that constitute a comprehensive outcome evaluation. Typically, program evaluation is limited to the collection of the data required by outside funding sources or by the LEA. Required evaluations are generally limited to process data, particularly counts—e.g., average attendance, number receiving health services, number of infants in child care, number of hours of counseling provided.

Project staff everywhere reported motivation to conduct comprehensive program evaluations, but said they did not do so for lack of funds. Each funding source requires—and funds—the collection of only a limited set of process data directly relevant to its own area of concern. For example, in one program, the county mental health agency provides funds for a unit on child abuse prevention. Required evaluation is limited to number of enrollees served and number of hours the unit is presented. Consequently, even by aggregating the disparate evaluations prepared for diverse funding sources, no true outcome evaluation is possible. No program staff felt the program could afford to divert its own already limited funds from direct

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figures, given that many students drop out without giving pregnancy as a reason; followup on dropouts is expensive, as discussed above.

service to evaluation, no matter how important such assessment might be in the long run. As a result, outcome data are often not available, and are of limited value when they are, based as they often are on the informal impressions of the project director and the reports of those students who choose to return to the program, either to display their successes or seek succor in their failures.

Yet the lack of outcome data cannot be too deeply regretted, because most of the evaluation models that staff would have implemented were inappropriate. A major problem is the absence of an available comparison group. As discussed in Chap. 4, schools often do not know a student is pregnant unless she transfers to an inclusive curriculum program; even when a pregnancy is known, it is not noted on school records. As a result, it is often impossible to identify a sample of pregnant students attending regular school.[32] Another common problem is the truncated temporal nature of these models, given the long-term goals of the programs. For example, one program whose director had kept what she described as "pretty good" records of enrollees, reported that over 80 percent were successful. She meant that over 80 percent of the enrollees who had not dropped out of the program prior to delivery had returned to the program at least once in the six-week postnatal period and had reported plans to return to regular school. However, no followup study was made, and the number who actually did transfer back to their former (or some other) high school was unknown. Data on school completion were not collected.[33]

Program staff tend to adopt a too-narrow time perspective concerning program effectiveness in response to a range of factors. Foremost is the pressure to serve as many students in need as effectively as possible. In the view of practitioners, research requirements are a luxury that cannot be purchased at the cost of denying services. In response to these pressures, program staff may collect data on students who are still involved in the program, but once they leave, the human and financial costs of followup escalate dramatically, and evaluation is usually discontinued.[34]

Another factor in the general failure of programs to conduct outcome evaluations is the indifference of many school district personnel to program outcomes. In some cases, this reflects views that the program is *ipso facto* effective in that it legally excludes pregnant students from regular school; the program would continue whether or not it was effective in other ways. In other cases, LEA lack of interest in outcome evaluation reflects a practitioner service orientation in which evaluation is an expensive frill. This latter orientation characterizes the views of many LEA administrators and explains the low level of LEA-initiated evaluations across programs.[35]

**Outcome Data.** A graphic presentation of the dearth of evaluation data among the programs we visited is available in Table 4. This table shows that evaluation in terms of the

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[32]Even if such a sample could be found, the fact of self-selection brings into question the comparability of the special program and regular school groups. (See Klerman, 1979, for further discussion of this point.)

[33]Klerman (1979) notes that short-time-frame evaluations could be both favorable and meaningful if program staff conceptualized and then measured the short- and intermediate-term goals that must be reached in order to realize longer-term objectives. For example, understanding and acceptance of contraception six weeks post delivery may be a more realistic program goal for a short-term program than delay of subsequent pregnancy. The short-term goal of contraceptive acceptance is certainly necessary to achieve the longer-term goal, delay of subsequent teenage pregnancy. One reason programs may fail to conduct meaningful short-term evaluations is that staff conceptualize program goals as long-term. If long-term goals were broken down into shorter-term objectives, staff might be more motivated to conduct careful evaluations when funds are not available for long-term outcome studies.

[34]Two programs in our sample collected process data, e.g., percent of eligible students served, using vital statistics data on teenage births as the denominator. Such evaluations are far less costly, less plagued with methodological problems, and often very useful.

[35]In most LEAs program evaluation is conducted only to comply with the requirements of outside funding sources.

## Table 4

### Available Evaluation Data on Program Goals

| Program | Generally Stated Goal: % Return to School Program[a] | % Subsequent Pregnancies | % High School Graduation |
|---|---|---|---|
| | *Inclusive Curriculum Programs* | | |
| A | Unknown (16% dropped out of program) | 65%[b] | Unknown |
| B | Unknown | Unknown | Unknown |
| C | 53% of one year's enrollment | Unknown | 11% of total enrollment for one year |
| D | 86%[b] | Reduced[b] | Unknown |
| E | Unknown | Reduced[b] | Unknown (former program attendees not distinguishable from others in regular school records) |
| F | 33% of total enrollment for one year | 12% of total enrollment for one year | 33% of total enrollment for one year |
| G | Unknown | None | Unknown |
| | *Supplementary Curriculum Programs* | | |
| H | Unknown | Unknown | Unknown |
| I | Unknown | 6% of total enrollment for one year | Unknown |
| | *Noncurricular Programs* | | |
| J | Unknown | Unknown | Unknown |
| K | 83% of active program enrollees continued in school and/or completed H.S. during a one-year period | Unknown | |
| L | 85%[b] | 1%[b] | Unknown |

[a] Includes return to any school program that serves nonpregnant or nonparent students.

[b] Entry represents data that are methodologically flawed because of failure to specify the time period for the evaluation, i.e., high school graduation measured over how many years? Klerman (1979) notes the difficulties involved in correctly calculating the results of long-term evaluations. Specifying a time frame is a crucial first step.

generally stated goals of special programs is uncommon. While a number of programs could provide information concerning enrollment and program attendance, data on the short- or long-term success of programs in terms of their own goals is the exception.

Outcome evaluations are a critical missing link in most of the programs we visited. While the reasons not to evaluate are many, lack of such evaluation denies programs the feedback they need to modify and improve the services they provide. A comprehensive evaluation may well show program success to be as time-limited as the programs themselves. Such outcomes could be used to lobby for a more comprehensive, expanded time frame for the program or other desired changes.

Outcome studies that cover a period of at least 18 months postpartum and preferably through high school graduation would shed light on a number of important issues that are poorly understood:

- What is the postpartum dropout rate? Many practitioners to whom we spoke believe that the first 2 to 6 months after a birth are the time students are most likely to leave school. The number of mothers who fail to return to a regular school schedule is believed to be substantial.
- Do inclusive curriculum programs that require enrollees to return to regular school at a prespecified time after delivery decrease the chances of return to and completion of a regular school program? The director of one program we visited that serves multiple LEAs indicated that in LEAs with more rigid rules concerning regular school return postpartum, fewer enrollees who leave the program return to regular school.
- To what extent do transfer policies facilitate or impede school continuation after postpartum transfer? A number of respondents believe that a major advantage of noninclusive programs is that no transfer (out or in) is required. Regular school staff continue to be involved with the student throughout her pregnancy and after delivery. In contrast, students who successfully transfer back from an inclusive curriculum are often treated as though they are new, nonparenting students. No extra counseling or help is provided.
- What program features contribute to enrollees' ultimate success as students and mothers? A tension between academic and "relevant" learning can be found in many programs. Does the emphasis matter in terms of school completion? Parenting? Every program head noted that a child care component is crucial to continued school attendance. Is this true?
- Do students do better when they attend regular school or other programs (e.g., adult school) after delivery? What accounts for their differential success?

**Comparison of Program Types.** In the absence of outcome evaluations from most programs, we obviously cannot offer a conclusive discussion of the relative strengths and weaknesses of the programs we visited in terms of enrollee effects. However, our observations illuminated a range of strengths and weaknesses in these programs that were consistent across sites, suggesting that underlying program models themselves influence program effectiveness, quite aside from variations in local program implementation. These strengths and weaknesses are discussed below.

Inclusive curriculum programs are generally effective in providing what they intend to provide—a warm, caring, sheltered environment in which students may feel free to discuss their problems and concerns. Their location away from regular school allows those who are embarrassed or harassed a chance to escape without dropping out of school. They also appear

to do a good job in providing and teaching "relevant" materials; coursework in nutrition, prenatal development, and parenting were the strengths of these programs.

Their underlying pregnancy-as-trauma model contributes to many of the weaknesses of these programs as well as their strengths. Probably their major weakness is their time-limited perspective. Program staff do not work with regular school staff in detecting pregnancies in order to begin prenatal care early, in spite of shared beliefs that early and continuing care is a program goal. More obviously, the strict time limitations on program attendance after delivery in most inclusive curriculum programs means that students must make the transition back into the rough and tumble of regular school at a time when the demands of parenthood and the transition to parent status may be taking a severe toll on their capacity to function effectively. The early transfer back to school is made all the more difficult by lack of any direct followup by program staff or significant efforts to engage regular school staff in monitoring school return and supporting school continuation. As a result, students may be thrust back into the often indifferent or hostile environment they sought to avoid by transfer to the inclusive curriculum program at a time when their needs may be greater than ever.

Another weakness of most of the inclusive curriculum programs we visited is the academic coursework. Program offerings are severely limited everywhere, and both program and regular school staff often viewed the academic curriculum as a maintenance effort. Such a focus might be appropriate for many, but our sense was that these programs were often so maintenance-oriented that even when it was inappropriate for certain individuals, little or no accommodation could be made. Some have argued that academics in such a program are appropriately secondary to relevant learning, and students generally spend less than a year in the program. Program staff also argue that the lower student-to-staff ratio compensates for fewer hours devoted to academic subjects and for other academic program deficiencies.

Nevertheless, the academic quality of programs is of much concern to referring staff and potential enrollees. As the embarrassment of pregnancy decreases (see Chap. 5 for a discussion of this point), students are less willing than in the past to sacrifice academic quality for the advantages that inclusive curriculum programs offer.

Noninclusive programs have a number of advantages and disadvantages, some of which are the mirror image of the strengths and weaknesses of the inclusive curriculum program model. A primary strength is that no transfer is required; students cannot get lost in transferring out or back, which is assumed to happen commonly. However, this does not necessarily mean that students do not get lost to the system. Supplementary curriculum program staff appear no better at engaging regular school staff in monitoring efforts than staff of inclusive curriculum programs, though their on-campus location may make it easier for program staff to keep track.[36] Noninclusive program models, which stress postnatal adjustment, motivate staff followup and concern. Often, young mothers may remain in or use program services (e.g., counseling, child care) well past the immediate postnatal period, which facilitates school continuation in many cases.

A major disadvantage of most noninclusive programs is that enrollees must remain in regular school.[37] If a student is embarrassed about her pregnancy or is the target of cruel jokes, she cannot escape into a protective environment. Junior high students may have to be transported to another site or attend a continuation school in order to receive supplementary curriculum program services, because the low incidence of pregnancies in junior highs does not

[36]In some cases, supplementary curriculum and noncurricular program staff have poor relations with regular school staff because of professional jealousies, as discussed in Chap. 4.

[37]One noncurricular program we visited serves dropouts. Program staff have been successful in reenrolling several in school.

justify on-campus services. There are other problems as well. A disadvantage in one program has to do with the linking of other program services with child care. If for any reason a student obtains child care help outside the program, she is not eligible for parenting classes or other program services. The reason makes some sense: Parenting classes include a lab component where parents work with their children; however this requirement so vitiates enrollment that the program serves less than 25 percent of those eligible. Since students generally prefer that their infants be cared for by a family member (Furstenberg, 1980), the program has limited its clientele to those lacking family support or resources.

### System Effects

Few of the programs in our sample have attempted to promote broader district concern for pregnant and parenting students. Program directors cited a number of reasons for not making these efforts, including a felt need to maintain a low profile, the press of direct service needs, limited funds, and the low probability of success they would encounter.

The isolation in which many programs were initiated continued through their implementation and strongly affects daily operations. Communication with regular school personnel, when it occurs at all, is not active. Flyers or pamphlets describing the programs are the major communication medium from special programs to regular schools. Phone calls of referral from regular school staff to the program when a pregnancy is discovered are often the only response. Policies in regular schools that affect pregnant and parenting students negatively are usually noted by special program staff but rarely challenged. Consequently, the programs in our sample have done little to improve their district's broader response to pregnant and parenting students. Although special program staff could act as advocates for pregnant and parenting students, this opportunity is rarely seized.

Ironically, the mere existence of the special program appeared to preclude a broader system response in several LEAs. Because regular staff and administrators in these districts view the special program as a sufficient LEA response to student pregnancy and parenthood, they have little inclination to do more.

### Long-Term Stability

Given the many constraints it faces, an LEA's initiation of a special program represents a significant commitment. Program continuation is expected; in only a few districts did the superintendent set conditions (such as total outside funding) for the program's longer-term existence.[38]

In our sample, the future appears secure for almost every program, though some of them will probably have to engage in a continuing fight for funds or undergo significant changes in operations, such as a change of sponsor or a reduction in services.

Some patterns emerged in examining the relationship between prospects for long-term stability and initial motivations to establish the program. Programs that were initiated in response to institutional needs to legally exclude pregnant students seem most secure; while

[38]However, it costs more to educate special program than regular students, as discussed above. Most programs in our sample receive substantial outside funds, often entitlement funds, that contribute to an apparently secure financial base for the program. If outside funds were to decrease or disappear however, cost would pose a genuine constraint on program continuation.

LEA administrators have done little to improve program quality or services, they are clearly committed to the program's long-term survival. Those programs initiated in response to recognized client needs were less secure. However, it was programs in this latter group that were most likely to receive strong and continuing superintendent support. Such support is always valuable, and may mean the difference between survival and extinction during a fiscal crisis. Two programs in our sample were experiencing such fiscal crises because of withdrawal of outside funds. In one case, material and moral support from the superintendent helped the program survive through a difficult period and secure stable state funding. A second program, lacking such support, faces an uncertain future.

# Chapter 3

# MODELS FOR SUCCESSFUL PROGRAMS

An important component of this study concerned the definition, identification, and documentation of exemplary settings. Initially, we intended to locate LEAs in which the dropout rate among pregnant students was lower than would be expected given student characteristics, general (nonpregnant) dropout rates, and other background variables. We would then visit two such districts—one with and one without a formal program for pregnant or parenting students. This strategy proved unworkable, however; no LEA or special program we contacted could provide us data on pregnancy-precipitated dropout rates. Respondents said a number of factors made collection of valid data impossible, including failure of LEAs to follow up over-age dropouts, unwillingness of students to give pregnancy as a reason for dropout, and lack of notation of pregnancy on school records to protect students' privacy. Other outcome data, such as percentage of pregnant students and mothers graduating from high school, were available in only a few sites, so that comparisons across sites or programs on these criteria were not possible.

We next elicited nominations of "exemplary" settings and programs from practitioners and others involved with teenage pregnancy and parenthood. The resulting list was dominated by large, full-day, inclusive curriculum programs located away from regular school campuses. Confining our visits only to programs of this type would have limited the usefulness of the "exemplary" portion of the study in two important ways: First, looking only at inclusive curriculum programs might have implied that this model is the only "good" approach. We had already encountered several districts that were not addressing the special needs of pregnant students and teenage parents in any way, because administrators believed that inclusive curriculum programs were the only way to serve this group but the cost was too high. Had we confined our attention to such programs, we would not have been able to present new ideas or models for possible use by financially less able districts.

Second, we were concerned that, in the absence of outcome data, nominators might be overweighting program inputs in making "exemplary" nominations. In an early fieldwork wave, we visited an inclusive curriculum program widely considered "exemplary," which provided a large number of services to program enrollees. When this program turned out to have a number of serious problems, we concluded that nominators might be overly influenced by a program's most visible features, particularly the array of services it offers.

Given the unavailability of outcome data and the potential biases of nominators, we decided to alter our approach, moving away from selection based on outcome criteria to selection on the basis of program model and a set of process criteria. While such an approach meant that we could not select our "exemplary" sites using generally accepted procedures for investigating program effectiveness, such an approach would allow us to highlight program models that some LEAs may not be aware of or consider when deciding how or whether to establish a formal program for serving pregnant and parenting students.

One potential drawback of our approach was that it overlooked the possibility that pregnant students and teenage mothers might be served adequately without a program. In a preliminary survey of LEA practices, however, we identified only one district that appeared to be doing so. Respondents in this LEA told us that the only reason they did not have a formal

program was that this small district had too few pregnant and parenting students to justify one. This lent support to our hypothesis that in the vast majority of LEAs concern would be translated into some form of programmatic response. Absence of a program would indicate either a low incidence of student pregnancy, lack of special concern for pregnant and parenting students, or both. In any case, it was reasonable to assume that LEAs without a special program were probably not effective in serving pregnant students and teenage mothers unless their numbers were very small.

Another potential drawback to our process approach was that it deliberately excluded inclusive curriculum programs from consideration, but this exclusion made sense on several grounds. (1) As discussed above, many LEAs equate a response to student pregnancy and parenthood with the establishment of an inclusive curriculum program. Such programs are generally regarded as costly and inefficient. We believed that highlighting other models might help LEAs to consider a variety of approaches. (2) Some inclusive curriculum programs have been evaluated and the results reported in the professional literature.[1] In contrast, few noninclusive models have been examined. (3) In our field visits to seven inclusive curriculum programs, we discovered that such programs, even those enjoying national acclaim, have a number of inherent limits due to their short time frame and physical and organizational isolation. For example, they may be costly, their academic curriculum may take a back seat to "relevant" learning, and enrollees may get lost to the system during the process of transferring out of regular school and back in after delivery. A look at other models would provide a broader framework in which to weight the advantages and drawbacks of inclusive curriculum models.

## THE NOMINATION PROCESS

We adopted a two-step nomination process. First, we compiled a list of programs that provide services to pregnant students and teenage mothers based on models other than inclusive curriculum models. From this list we selected several approaches that were not already represented among our eight fieldwork sites.[2] From among this group we selected two programs that came closest to meeting a set of exemplary process criteria that we developed over the course of the project.

These criteria were:

- Percentage of eligible students served;
- Level of coordination with other community agencies involved in serving this population;
- Quality of resources available to the program;
- Level of district and community support; and
- Extent and quality of services provided.

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[1]See Bennet and Bardon, 1977; Ewer and Gibbs, 1976; Klerman and Jekel, 1973; Howard, 1968; and Richardson, 1966.

[2]Six of the eight programs we visited during the fieldwork phase were inclusive curriculum programs. In the other two fieldwork districts, and in the eleventh (additional) district we visited, noninclusive programs were operating. Consistent with our desire to learn as much as possible from our sample, we selected for visits during the "exemplary" phase noninclusive programs based on models not represented in the fieldwork sample. (One of these districts ran both the noninclusive program and an inclusive curriculum program. We visited both.) Once the exemplary programs were chosen, we went back and applied the process criteria used to select them to the noninclusive programs visited earlier. One program met several of these criteria and is included in the discussion of exemplary program models in this chapter.

In determining how well a nominated program met our process criteria, we validated its status on each criterion to the extent possible. For example, we compared live birth rates with program enrollment as a means of assessing the validity of reports concerning the percentage of eligible students served; we contacted other community agencies to ask them about the extent to which they were involved in the program.

This lengthy procedure allowed us to select for "exemplary" site visits, two programs that appeared to meet our process criteria. A third model visited during the earlier fieldwork phase is included as exemplary in this discussion because it met several exemplary process criteria and has significant potential, though it was poorly implemented.

The discussion in the next section briefly describes our three "exemplary" models; it then describes the programs as they operate in their respective sites.

## EXEMPLARY PROGRAM MODELS

*Program K* is based on a noncurricular model.[3] Each enrollee attends regular school and is assigned to a program counselor, who renders tutoring and counseling services and is responsible for establishing linkages to those community services needed by each young mother in her caseload.

The rationale behind Program K is that both pregnancy and parenthood can threaten a young mother's school completion and personal development. Young mothers are seen as having a range of special needs that must be addressed on a continuing basis in order to facilitate school continuation and graduation.

The Program K model assumes two major program objectives: (1) school continuation and graduation, and (2) establishment of a community service network for program enrollees. For a high school senior, participation might be limited to a period of several months; for a 7th grader, program involvement would likely last five years. It is significant that program involvement may continue until high school graduation even if the student drops out of school for a period of time.

*Program L* is prevention oriented and noncurricular. It locates primary medical care clinics in high schools in order to achieve two major objectives: (1) to provide prenatal care to students who may not seek out care in other community-based clinics, and (2) to reduce the rate of pregnancy through counseling and provision of birth control information and devices. The clinics also provide health maintenance services to all students, and provide pediatric and child care services to the children of students.

The rationale underlying Program L is that teenagers need health and related services, but may find access to them difficult when they are located in the community instead of the school. Teenage parents in particular need prenatal care and a range of support services in order to continue in school.

Enrollees in Program L attend regular school and receive prenatal care, counseling, birth control information and devices, pediatric and child care for their children, general medical services, and health education on both a drop-in and appointment basis.

*Program J* operates on a noncurricular model. Enrollees attend regular school and receive counseling from a program social worker about once a week during school hours. A team of concerned faculty members at each participating school identifies and refers pregnant students to the program social workers and counsels them at times when the social workers are not available.

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[3]Identifying letters correspond to those in Tables 1, 2, 3, and 4.

Counseling done by the social workers includes supportive therapy, provision of information, referrals, help with decisionmaking, and assistance in resolving problems that threaten school attendance. Most work is done on an individual counseling basis. Help is available throughout pregnancy and continues to be available until a student completes (or leaves) the participating high school.

### Exemplary Program Descriptions

**Program K.** Program K is a regional program serving six school districts.[4] The program grew out of the concerns of the LEA coordinator of home teaching, who noted that the schools displayed little sensitivity to the multiple needs of pregnant students and teenage mothers. As a result, many students dropped out when they became pregnant, and nearly all who remained enrolled through pregnancy left school by six weeks after delivery, when home teaching eligibility was terminated. She took her concerns to the superintendent, who supported her in her efforts to establish an LEA-funded pilot program. This program served nine 9th grade students who had been on homebound instruction. Program services included tutoring and counseling and establishment of linkages to a range of community services.

The pilot program convinced the coordinator of home teaching that the major needs of parenting students were counseling and outreach; academic needs could be met effectively enough through regular school attendance and time-limited homebound instruction. In her view, school dropout occurred because young parents could not cope with school demands when they had many unmet needs such as child care, housing, and social support. If these needs could be addressed, regular school attendance would be both possible and appropriate. At the end of the pilot program the coordinator of home teaching met again with the superintendent, who supported her in her conclusions and in the writing of a proposal for external funds. The proposal was funded.

Program counselors generally receive referrals from school personnel or from a worker in one of the many community agencies that compose the project's network. An intake interview is arranged and is usually conducted in the enrollee's home with her parents' participation. The intake interview focuses on needs assessment, with the potential enrollee playing an integral role. Once she agrees to participate, the counselor acts as the advocate for her and her family and as the liaison person for all service needs.

During the intake interview, a pregnancy plan is discussed, including educational, health, and social implications and options. Students who choose abortion or adoption are referred for these services. Those who leave the community to deliver may return for post-adoption counseling and educational assessment; those who remain in the community may use program services on a continuing basis.

The program operates out of a portable building annexed to a high school. Each participating high school also provides a counseling space for program staff. Program counselors visit junior highs on request and use assigned space as the need arises. Most counseling occurs in enrollees' homes, however.

Program K staff work cooperatively with school counselors and out-of-school educational personnel in developing assessments and considering options such as adult education, regular

[4]Some program details have been altered to maintain anonymity, which was promised participating sites. However, no changes have been made in the description of the basic program model or its implementation.

school, homebound instruction, and tutoring. Enrollees receive needed health services according to a plan supervised and coordinated by the Program K counselor. Program volunteers with appropriate professional backgrounds directly provide health counseling, Lamaze instruction, and postnatal instruction. Counseling sessions with prospective fathers and grandparents are conducted when appropriate.

Program staff have developed a profile of community agencies that provide services to young mothers. Needs for housing, financial assistance, and day care are addressed through counselor coordination with these agencies. Enrollees are seen by their program counselor at least once monthly during their enrollment in the program. The staff includes a director and three counselors. At the time of our visit, there was an active caseload of 80. According to the director, the program serves more than 80 percent of those eligible.

**Outcomes.** An evaluation conducted by outside investigators to fulfill the requirements of outside funding sources suggests that the program is doing well. Fully 83 percent of active participants made progress toward or completed their secondary education during the evaluation period, and 100 percent of the agencies offering relevant services knew of the program. Less formal assessments point to program success as well. The director of pupil personnel services observed that pregnancy-precipitated dropouts are less common since the program has been operating. A high school counselor believes the program has directly helped enrollees a great deal, largely because of the director's dedication, program outreach, and the active referral system.

This program model is strong for several reasons. First, the program makes a commitment to the pregnant young person that continues until she finishes high school, regardless of her pregnancy resolution decision or whether she drops out of school at any point. Thus, the program is available to *all* pregnant students and may help dropouts to return. Second, program counselors feel responsible for arranging *any* needed service. The fact that available community services are used as much as possible allows the program to accomplish a great deal with few staff members. Third, enrollees need not transfer out to the program and back in to regular school after delivery. Respondents in many sites noted that students often "fall through the cracks" in the transfer process, particularly after delivery and during term breaks.

**Program L.** Program L is a system of primary care health clinics located in high schools in a moderate-sized city. The program is a joint effort between the schools and a local medical center to provide prenatal care to students who were not receiving it, and to reduce a high pregnancy rate. As a medical facility, the clinics emphasize health care, but have a strong preventive and counseling focus.

The in-school clinic idea was appealing to the LEA superintendent on several grounds. The clinics would provide medical, social, and child care services on campus, thereby supporting school completion for pregnant students and teenage mothers, as well as providing health maintenance services for all students at no cost or responsibility to the LEA. The medical center was successful in assembling a package of funding sources for the project, including Title V, Maternal and Infant Care, Title XIX, and state funds.

Each clinic is staffed by a family planning nurse practitioner, who serves as the site director, and a social worker, both of them present whenever the clinic is open. A range of other health professionals, such as an ob/gyn, pediatrician, nutritionist, and internist have a regular clinic time each week. Students may use the clinic on a drop-in basis, though in response to teacher complaints, clinic staff encourage appointments to minimize time away from class.

Pregnant students receive full prenatal care, including gynecological exams, coursework in prenatal development, and a life skills/counseling group. A mothers' group is available on an ongoing basis. Child care and health care for babies is also provided. Clinic staff stress

preventive services, particularly (off campus) dispensing of contraceptives.[5] Staff are sensitive to the many factors that may diminish contraceptive acceptance and compliance, and try to establish an individualized system for monitoring each student. Their in-school location facilitates such monitoring, which may occur as often as every day. Staff may also suggest contraceptive devices more consistent with irregular adolescent sexual behavior, such as diaphragms and condoms, although such devices are generally seen by medical practitioners as less effective. According to the director of one of the clinic sites, the clinics serve 80 to 90 percent of known term pregnancies.

**Outcomes.** Program L has collected a large amount of outcome data. However, because of the program's medical orientation, most data focus on medical rather than educational outcomes. The findings of evaluation studies indicate that, on a range of measures, the in-school clinics produce better results than adolescent clinics located elsewhere in the same community. For example:

- A higher percentage of students attending the in-school clinic began prenatal care in the first trimester.
- Pregnant patients using the in-school clinic averaged more antenatal visits.
- Rates of anemia, toxemia, and urinary tract infections were lower.

Clinic staff attribute the superiority of the in-school clinics to the greater accessibility of the school location, and the fact that follow-up and monitoring are facilitated by having patients in the building.

Fertility rates have also decreased substantially in clinic schools, because of both a reduction in conceptions and an increase in abortions. Staff report that subsequent deliveries among clinic users are rare. Unfortunately, no firm figures are available on school completion, though clinic staff estimate a rate greater than 85 percent.

This program model is strong because it serves all students on campus, avoiding problems of transfer and isolation. Students who choose to abort a pregnancy are as welcome as those who carry to term. A particular strength of this model is its preventive focus; most other programs we visited and learned of concentrate on those who are already pregnant. However, its strengths may be seen as drawbacks to many who contend that medical services, and contraceptive counseling in particular, are not appropriate school functions.

**Program J.** Program J is a noncurricular program that provides services to approximately 40 parenting and 40 nonparenting students in six of the district's high schools. Its focus is on counseling and prevention of subsequent teenage pregnancies among its pregnant clientele.

The impetus for Program J came from the directors of home economics and social work. Passage of a state law barring exclusion of pregnant students led to attempts by some principals to transfer pregnant students to other districts. The two directors believed that some positive programmatic response to student pregnancy should be undertaken. They approached the superintendent about conducting a needs assessment. Not entirely supportive, he allowed a needs assessment but did not allow them to speak to students. Through a network of school site counselors and other teachers, 90 pregnant students were found to be enrolled in the district in one school year. This figure, which was assumed to represent less than half of term pregnancies, supported the need for a program.

Discussions with the superintendent, however, made it clear that the LEA was not willing

[5]The superintendent made it a condition of clinic approval that contraceptives were not to be dispensed on school campuses. Clinic staff conduct the exam, counsel about methods, and monitor compliance. Contraceptives are available at a clinic very close to each in-school clinic site.

to pay for a special program. The two women thereupon sought and received funding from a local agency that funds programs for children.

The program has two components: counseling provided by social workers, who visit each participating high school one day a week, and a team of concerned faculty members at each participating school who identify and refer pregnant students and counsel at times when the social worker is not available. Social workers provide individual supportive therapy, information, referrals, help with decisionmaking, and assistance in resolving problems that threaten school attendance. Faculty teams comprise concerned teachers from all disciplines. A series of training sessions conducted by project social workers are provided them each fall, and they are encouraged to meet regularly in order to compare experiences and provide mutual support.

**Outcomes.** No formal evaluation of any kind has been made of Program J. The Supervisor of School Social Workers affirms that the program has been highly successful; the incidence of subsequent pregnancies has declined, and more parenting students finish high school.

The particular strength of this program model is that it actively involves regular school staff, who receive training in pregnancy detection and counseling. It serves students at the school site, and receives referrals from faculty team members, who, because of their interest and training, are aware of pregnancy and likely to detect it early.

## STRENGTHS AND WEAKNESSES OF PROGRAMS K, L, AND J

### Continuity

A major strength of all three program models described above is their commitment to providing continuing services to pregnant students and teenage mothers through motherhood to graduation. Program K is particularly strong in this respect because it is available to parents and parents-to-be at any grade level and stays with them even if they drop out of school. Most program heads reported that in recent years more junior high school age students have needed program services. Many inclusive curriculum programs serve young enrollees, though often no special arrangements are made to accommodate them. Because they are often located within high schools, noninclusive programs frequently are not able to serve younger students. Program K is able to do so. All three programs provide services that are not contingent on a pregnancy resolution decision; Program K explicitly offers postabortion and postadoption counseling, while Programs L and J are open to any student of a participating high school.

Program K's attempts to acquaint enrollees with community service agencies and what they can offer help to foster independence from the program, at the same time that the program meets immediate needs in making these referrals. This orientation toward "life after high school" is missing from nearly every other program we visited. Said one program head, "I think getting girls through high school is very important, but then they're *completely* on their own. Post high school support systems are critical and lacking."

### Percentage Served

Although no program could provide a confident figure about the percentage of eligible individuals served, Program K seemed to be serving a high percentage. Several factors contribute to its success in this regard: (1) Program staff have excellent relations with many agencies

that work in relevant areas. These agencies often refer potential enrollees. (2) Staff make active efforts to locate dropouts. (3) Staff are very willing to go to enrollees' homes to provide services. Said the Program K director, "outreach is critical. Many girls will not seek assistance, no matter how badly they may need it. Programs that depend on girls coming to them are missing a lot (of potential enrollees)."

Estimates of the percentage of pregnant teenagers served by Program L varied enormously. A major factor is that the Program L LEA has an inclusive curriculum program as well as the clinic program. While a choice of programs is desirable for potential enrollees, many school staff view the programs as competing for enrollees; they may bias their enrollment estimates according to their loyalties.

Many programs lose potential enrollees because they depend on regular school staff to identify pregnant students and follow up dropouts. Special program staff could do more to engage their cooperation and support.[6] The Program J model is exemplary in this regard for identifying and "deputizing" regular program teachers to serve as scouts, referral sources, and back-up counselors.

### Agency Involvement

The involvement of community agencies in special programs is advantageous for many reasons. Their help is critical for programs that provide few direct services. For those that provide many services, community agencies may furnish staff, equipment, or consultation. For all programs, agency staff may serve as an important referral source and a source of support for the program in the community. In programs with active community agency support, enrollees have an opportunity to become acquainted with community resources they may need and use long after they leave a special program. Some programs consciously facilitate enrollee knowledge of community agencies by arranging field trips or bringing in agency speakers. Directors of many programs try to introduce enrollees to at least one person in each agency so that they will have a name and a contact should they need services in the future.

Program K owes its great success in engaging the active support of community agencies to several factors. First, program staff are highly committed to this approach. They believe that duplicating available community services is both costly and unnecessary. They also believe that active community involvement in service delivery contributes to a more supportive community environment for young parents. Second, the high priority of agency involvement has been institutionalized in the creation of a Community Coordination Specialist position in the program. This person's job is to establish and maintain good working relationships between the program and relevant community agencies. Third, the commitment of staff is enormous. Each counselor is committed to overseeing the total care package for an individual enrollee. Counselors typically give enrollees in their caseloads their home phone numbers and it is not unusual for a counselor to rush to the delivery room in the middle of the night.

### Exportability

Program J's model of in-school counseling is highly exportable to other sites, particularly rural sites where distances preclude the possibility of an inclusive curriculum program. Simi-

[6]In one LEA, not a single mother transferred to an on-campus supplementary curriculum parenting program from an off-campus pregnancy program. Parenting program staff did not know why, but their failure to recruit or even visit the pregnancy program certainly was a factor.

larly, the model for Program L may be exportable, since a critical mass of *pregnant* students is not necessary to make an in-school clinic successful. The Program K model is also exportable, since staff can be hired in proportion to the number of pregnant students and teenage mothers.

## PROGRAM MODEL IMPLEMENTATION

A good program model may be necessary but certainly not sufficient to ensure a good program. How well a program actually works depends on how well the program model is translated into practice. In the course of our visits to our "model" programs, we identified three factors that appeared most important to successful implementation.

### Staff

Staff qualifications and enthusiasm are of primary importance. Many respondents noted that the commitment and enthusiasm of the director in particular is critical. The dedicated directors we learned about felt a strong personal as well as professional commitment to the program. Often, they had long years of experience in the LEA and had earned respect that helped them keep the program running. Sometimes they were young, and saw the program as an opportunity to do something different and help students in need. The program gave a few of them a new professional status as principal or director. In a few cases, program staff received additional pay as special education teachers, but financial incentives appeared to be a negligible factor in staff commitment.

In the limited sample of programs we visited, an early and instrumental involvement in the program's development were associated with director enthusiasm. For staff, some sense of ownership appeared critical.[7] In one of the more poorly implemented projects, Program J, staff turnover was high at all levels. New social workers did not feel the personal commitment to the project that their predecessors had felt. Social workers did not take responsibility for the total care package for an individual; often, referrals to outside agencies were made but not followed up. One problem was that program social workers were now supervised by the coordinator of social workers for the LEA, who had 33 other social workers under him; the special program coordinator position had been eliminated in an effort to save funds. The program staff thereupon lost their "special" status, from which enthusiasm often flows. A second factor was that they were hired by the social worker director; he may not have looked for the "self-starter" qualities their predecessors had possessed. They are now merely two more school social workers who seemed to take on the more limited responsibilities typical of regular school social workers rather than the broader responsibilities often found among "special" program staff, such as those in Program K. Faculty team members had stopped meeting, thinking it pointless to devise plans and strategies since each new set of social workers seemed to want something different. Lack of any financial incentive to meet may have quickened the demise of the faculty teams, but instability of program leadership was the key.

In Programs K and L, staff and director enthusiasm were high. Program K is run by its

[7]Studies of program implementation underline the importance of staff and director enthusiasm, which often stem from perceived ownership of the program (Greenwood, Mann and McLaughlin, 1975). A number of the program directors we interviewed were approaching retirement and were concerned about finding enthusiastic replacements. How serious a problem this will be is unclear. However, we did encounter two "second generation" program directors. Both appeared enthusiastic and committed. (See Chap. 2 for further discussion of staff recruitment.)

initiator, a woman who feels a strong commitment to helping pregnant students and teenage mothers. After long service in a small district, she has the superintendent's ear and his continuing support for the program. Program L is run by site directors in each clinic who report to supervisors at the medical center. These directors are young and were recruited especially for the job. Both see their job as a unique way to deliver services to teenagers who might otherwise not receive them. Clinic staff see their school location as a way to reduce the compliance and followup problems that are common among teenage patients. Each clinic operates with little direct supervision, so that clinic staff set their own policies and solve site problems together. Staff receive strong support from medical center personnel, and support from the superintendent as well.[8]

### Coordination with Regular School Staff

Pregnancy and parenthood, while clearly major events in a young person's life, are only one set of roles that must be fulfilled by a parenting teenager. School and social roles are also important. Special programs, whether they cloister enrollees for a brief period or serve them while they attend regular school, must coordinate with regular school staff to promote successful multiple role integration. For inclusive curriculum programs, coordination must center on facilitating transfer in and out of the program. For noninclusive programs, coordination needs to be ongoing, with concern for the integration of the roles of parent-to-be, parent, student, and teenager.

Few programs we visited have been successful in establishing or maintaining coordination between their own and regular school staff. Many attempt some coordination, but these attempts are frequently superficial and often ignored. Typical were the efforts of one inclusive curriculum program. Program staff had prepared a brochure which they regularly distributed to school counselors as well as staff members of community agencies and private doctors. The brochure presents the program model, describes referral and enrollment procedures, and includes the program's phone number, which counselors readily call when a pregnant student is identified. However, this is the extent of the coordination. Counselors rarely visit the program and may or may not read the brochure. Few attempts have been made by program or regular school staff or by LEA administrators to arrange joint staff meetings or training, to smooth transfers, or to facilitate regular school adjustment after delivery.

We assumed that programs located in regular schools would be more successful in working with regular school staff because they shared the same building, principal, and lunchroom. More often than not, this was not the case.[9] Supplementary curriculum programs are often viewed with some hostility by regular program staff, particularly health and home economics teachers and nurses, because of fell threats to their jobs or "turf." Overtures by special program staff were often viewed as takeover attempts. One supplementary curriculum supervisor had cautioned staff to maintain a low profile, so little coordination was attempted. In another, staff concerned about maintaining their image to students as "nonschool" made only cautious and limited attempts to coordinate, and these were often initiated only after problems emerged.

Failure to establish close working relationships has much to do with the attitudes of regular school staff, who often do not want to deal with student pregnancy and parenthood, either because they do not regard it as an appropriate school function, or because they felt over-

[8]The directors of Programs L and J noted that stable, committed staff may suffer burnout. Formal inservice training as well as informal sharing of problems helps to reduce this problem.

[9]In one instance, the regular school nurse was unable to direct Rand site visitors to the office of the program nurse.

burdened. Staff in this latter group are pleased that the program exists and are happy to refer, but want no further involvement.[10]

Coordination might have been improved in many cases if district higher-ups had stressed its importance and acted as facilitators. This occurred in only one site, and the attempt was minimal. In this case, the inclusive curriculum program was designated a school, and its supervision transferred from the director of special education to the director of secondary education. It was believed that the program's academic curriculum would be strengthened and more related to regular high schools in this way.

Coordination is more likely if the special program sees coordination as a central program function. Program K staff believe such coordination is critical to success. Coordination between Program K and regular school staff is the closest and most productive we saw in any site. Many programs fail to develop that degree of coordination because the program model stresses intensive, short-term, direct services. Given that model, coordination seems an ancillary function for which limited staff cannot be spared except for brief periods. In other cases, special program directors fear that they will engender more hostility than good will by contacting regular school staff. Typical was the response of the director of one supplementary curriculum program: "Right now, the less visible (the program) is, the better off we are. As the program gets more established, we hope that the good results we produce may win us more friends (among regular school staff)."

### Administrative Support

In the sites we visited, the extent of support for the program at the top levels of LEA administration influenced the program's implementation and effectiveness. In many sites, supportive superintendents allow program directors full discretion in the choice of staff members from within or without the district. These programs tend to have enthusiastic, dedicated staff.

In several sites, supportive superintendents were actively involved in program initiation. In the Program L site, the superintendent was enthusiastic about the program model, and met frequently with high school principals to describe the program and encourage their participation. Although the principals were assured of their right to refuse the program access, principals of the two high schools the program most hoped to attract because of high pregnancy rates ultimately cooperated. Superintendent enthusiasm "undoubtedly played a role," according to the project director. In contrast, in the Program J site, lack of high level support limited the program's expansion to additional schools, although the project had sufficient resources to do so. As a result, the program diversified its clientele in the schools in which it already operated. At the time of our visit, only 50 percent of program participants were pregnant or parenting students. The others used program counselors to discuss family problems, including divorce, sexual abuse, and other teenage problems. While such problems are worthy of attention, the program seemed to have lost its focus at the same time that pregnant students and teenage mothers in nonparticipating schools were denied needed and potentially available services.

A few supportive principals have acted to assist special programs in their buildings. One principal paid for a part of a program staff member's salary out of building-level discretionary funds. Another meets regularly with program staff to discuss and anticipate problems. None,

[10]See Chap. 4 for a discussion of pregnancy and parenthood in regular schools.

however, has acted to encourage coordination (or reduce hostility) between regular and special program staff.

## CONCLUSIONS

Based on our visits to 12 programs, we cannot advocate a single program model that would be best for any given LEA. The success of a program depends significantly on how well it fits its environment. Community and school staff attitudes, level of resources available, geographic dispersion of students, and number of pregnancies, among other factors, have a bearing on the best program model and on its successful implementation. For example, in a very open and accepting community, a noninclusive program may be the model of choice, because most pregnant students will not be made to feel embarrassed to be in regular school. In a community where family ties are strong, a program that requires teenage mothers to bring their babies to the program's child care center in order to receive other services may serve few.

Inclusive curriculum programs in rural areas may not be able to attract sufficient numbers to sustain their operation, and will almost certainly fail to serve a substantial percentage of those eligible. Pregnant students, or any students for that matter, resist very long bus rides, and often program funds can be better spent bringing the program to potential enrollees. Similarly, when small numbers of pregnancies occur in the district as a whole, inclusive curriculum models may not be feasible, since a critical mass is not available to ensure the provision of needed services on site. The identification of the best model for a community should be made by community people actively considering a range of options.

## COMPONENTS OF EFFECTIVE PROGRAMS

Although we cannot recommend one "best" model, our visits and subsequent analyses of the strengths and weaknesses of the programs we saw led us to formulate a set of components that can be included in any of the program models we saw that will contribute to program effectiveness. Some of these suggestions are simple to implement, and others difficult or impossible in some settings, but all are worth considering.

### LEA Commitment

Regardless of program model, level of resources, or staff dedication, every program we saw was affected by how strongly committed LEA administrators, particularly the superintendent, were to the program. Active superintendent support would have smoothed the way for many programs that experienced hostility, financial shortfalls, or staffing difficulties. Active support may include public (media) support and meetings with principals in which their support for the program is elicited as well as direct support to the program.

Principals could provide much support to programs, though they rarely do so. One way would be to simply *discuss* student pregnancy and parenthood with staff, noting that it happens at their school. Statements indicating that school staff are expected to pay attention to possible pregnancies and actively become involved may encourage regular school staff to do more than phone the program when a pregnant student comes to their attention. One principal in our sample engaged staff support by establishing a system of committees composed of appropriate staff—e.g., nurse, school social worker, counselor, teacher—who meet and plan special pro-

grams for students with special needs. Reports of committee meetings are sent to and read by the principal. This policy legitimizes regular school staff involvement with and concern for "special" students, and at the same time sets up a mechanism for doing so.

### Programmatic Alternatives for Pregnant Students and Teenage Mothers

As recently as the 1960's, the establishment of a school-based program for teenage parents was a brave and significant step by a school district. It still is, given the many constraints facing districts today. The social context is changing, however, and as a result the advantages and weaknesses of special program models may be shifting as well. As pregnancy and parenthood have become less stigmatized, and the constraints imposed by embarrassment or shame decline, numerous pregnant high school students are carefully examining their options and choosing not to transfer to inclusive curriculum programs. In so doing, however, they are forgoing extra services or help they might need. At the same time, as more young adolescents become pregnant, the need for inclusive curriculum programs continues. As discussed in Chap. 4, in most junior high schools staff agree that remaining in regular school during pregnancy is difficult or impossible. Frequently, noninclusive programs, particularly those located in high schools, are not available to junior high school students.

Obstacles to providing true programmatic alternatives are substantial. Communities that tolerate one program may regard two as too many. And as we saw in one site with two programs, the programs themselves may compete for enrollees or engender competition and hostility in regular school staff. Some regular school staff believe that when an inclusive curriculum program is available, those who choose not to enroll in it should expect no special help in regular school. However, such a belief denies pregnant and parenting teenagers true equality of educational opportunity. If the courses they want or need are available only in regular school, it seems unjust that they should have to choose between educational progress and needed services. Some provision of services in a range of settings, however minimal, will allow more students to make good *educational* choices and still receive the services they need.

### Continuing Concern and Support

A key factor in ensuring school success for pregnant students and teenage mothers is some continuity of concern, support, and services. While some young mothers may take on the parenting role with ease because of personal strength, a supportive partner, or family support, most find it difficult. When problems occur, school may begin to seem burdensome or impossible.

Yet in many ways, regular school staff are neither interested nor equipped to handle such problems, as discussed in Chap. 4. Special program staff cannot assume that regular program staff will take a special interest in a new mother who has just left their program. Therefore, some thought should be given to ways of providing some continuity. Some program models, e.g., programs K, L, and J, include continuity of services in the basic program model. Other models, including inclusive curriculum models, could accommodate some policies that promote continuity of services. For example, one staff member could be responsible for followup. She could contact the school counselor or the young mother herself once a month to check for school attendance and any problems. She might make herself available for counseling for those in need. Special program directors often agree that continuity is a good idea, but cite lack of time or money to devote to it. It does cost something, although "mothers' groups" or monthly

"reunion parties" are relatively inexpensive. Continuity seems to pay off, however. Many respondents—both adults and adolescents—state that the postnatal period is often the rockiest. Ignoring needs at this time may undermine the advantages afforded earlier by a special program.

# Chapter 4

# STUDENT PREGNANCY AND PARENTHOOD IN THE REGULAR SCHOOL CONTEXT

The manner in which regular school staff treat student pregnancy and parenthood is of major importance to the school careers of student parents, even when the district has established a special program to meet some of their needs. Special programs, particularly those located off-campus, rely on regular school staff for identification and referrals. In districts where the special program is time-limited or located on campus, student parents attend and may depend on the regular school for help in maintaining attendance in the face of problems surrounding child care, parenting, and related issues. The question, then, is how willing regular program staff are to assume these responsibilities and how well they perform. As discussed in Chap. 2, special program staff generally assume that regular school staff willingly extend help and support to pregnant and parenting students. This chapter examines that important assumption in some detail.

## SCHOOL SITE POLICIES

### Formal Policies

None of the 30 regular schools we visited has a comprehensive written policy concerning all phases of the treatment of pregnant students and teenage mothers.[1] If a policy exists at all, it is usually limited to issues such as excused absences, doctor's notes, and time out for delivery. In most cases, lack of an explicit policy reflects the absence of a formal policy at the district level. Given that LEA administrators neither require a school site policy nor have developed one of their own, school staff seem quite happy not to have one. Said one school staff member, "A policy indicates a problem and nobody wants to admit one exists." In one LEA the lack of school site policies in either of the high schools we visited was more strongly motivated. Many regular program staff in this site told us the LEA had been sued several times by students who claimed that they had been treated at variance with stated policy. Lack of a policy therefore avoids the possibility of such lawsuits.

### Informal Policies

In the absence of formal policies, districts and schools in our sample established fairly elaborate and remarkably similar procedures for dealing with pregnancies. A major feature of these policies is the widely shared belief that pregnant students should continue their schooling with as little interruption as possible. Everyone agrees that it is to no one's advantage to banish

[1]This includes vocational high schools and all other schools that students in our sample might attend when not pregnant.

students from educational settings for the duration, though tolerance for pregnant students within the regular school is less widespread, as discussed below.

In many districts, these policies embody a strong central tenet; in several sites, for example, transfer to the inclusive curriculum program as soon as possible was the governing aim. The content of the policy was shaped in several sites by the strong views of the superintendent. For example, in one site the superintendent believes that pregnant students should not be isolated; and school staff are aware of his belief. Transfer to the inclusive curriculum program is never suggested to pregnant students in this district.[2]

In a number of sites, the view that early transfer to the inclusive curriculum program is the treatment of choice is often reinforced by other informal policies. In one LEA, the district provides inservice training on pregnancy management to inclusive curriculum program personnel but not to regular school staff. As a result, regular staff inclinations to urge transfer are reinforced by beliefs that special program staff are more expert at handling pregnancy.

## PREGNANCY POLICIES

### Detection

Little time and few resources are devoted to increasing regular school staff awareness of student pregnancy and parenthood. We saw no case in which the principal had used her or his position to make the issue salient. Indeed, the principal has little or no involvement in student pregnancy and parenthood in any school we visited. None was able to give us a confident estimate of the number of pregnancies in the school the previous year; some could not even make a guess. Said one principal in a typical reply, "I know we had some last year. Mrs. ——, the nurse, handles them. You should talk to her." Another principal was unaware of the existence of the inclusive curriculum program, which had been operating for eight years. He believed pregnant students were placed on homebound instruction, as had been done in the past. No principal in our sample had ever brought up student pregnancy and parenthood in a faculty meeting. Several offered as a reason the fear that staff would become overzealous and falsely accuse students of being pregnant. A few believed that there was nothing to discuss—that informal arrangements existed to handle the problem. Several, particularly junior high school principals, said the number of pregnancies was so small that there was nothing to talk about. Conversely, in one large urban high school, the principal said pregnancy was never discussed because it was "so common." Principal non-involvement reflected and reinforced the views of many regular program staff that student pregnancy and parenthood should be ignored if possible. While some action must usually be taken when a pregnancy becomes known, elaborate planning, discussion, or training would be an unwelcome diversion from regular work.

### Referrals

The procedures schools have established to deal with student pregnancy generally include the following elements: First, when a pregnancy is suspected or known, a school counselor or

[2]The inclusive curriculum program in this district is part of a continuation school, and is generally considered inappropriate for those who are "just" pregnant. Whether the superintendent's views about mainstreaming influenced the poor quality of this program is unclear.

nurse should be informed. Second, this person is expected to inform a student of her educational options and make appropriate health and other social service referrals. Third, the student is referred to the special program; and fourth, students who are willing (in the case of inclusive curriculum programs) are transferred out of the regular school into the inclusive curriculum program. Each of these elements is discussed below in turn.

Either the student's counselor or a school nurse is typically the person "in charge" of pregnancy. The designation seemed the natural outgrowth of earlier policy in many cases. For example, in one LEA school nurses had always been the in-school coordinators of home teaching. Prior to the establishment of the inclusive curriculum program, pregnant students had been placed on home teaching. Nurses continue to "handle" pregnancy at all the high schools in this LEA. In other LEAs, the student's counselor is the logical choice because the school nurse is available on only a very limited basis. In no case was the choice of "responsible" person made on the basis of willingness, expertise, or commitment to pregnant students and teenage mothers.

The "contact" person receives referrals from teachers, counselors, and other staff members when a pregnancy is suspected or revealed. Sometimes the student herself reveals her condition (or suspected condition) to a trusted teacher or counselor. Frequently a gym teacher notices symptoms or physical changes in a student's body or notes an uncharacteristic pattern of absences or withdrawal from PE. Sometimes the student's friends voice their concerns to a teacher, counselor, or nurse. Despite these varied sources of information about a pregnancy, it is not uncommon for school staff to learn of a pregnancy for the first time when a student's parents contact school staff to inquire about educational options. This inquiry is usually made only after all other pregnancy-related matters have been decided. This arrangement has advantages for the school in that it ensures no school role in pregnancy resolution decisions; as discussed below, most school believe these decisions are personal and not the business of school staff.

Staff referrals are either initiated in response to physical signs of pregnancy or to parent or student inquiries. As a result, most referrals are not made until well into the second trimester. Many times, students who make even minimal efforts to hide their condition escape detection even longer. One teacher told us that detection is more likely at certain times of the year than others: "In April and May we see a lot of pregnancies for the first time. They just can't hide inside bulky winter coats any longer." A few students may escape detection completely. In one high school we visited, a student had delivered a full-term baby on the floor of the restroom the previous spring. No one at school had known she was pregnant. Her counselor told us, "It was pretty embarrassing. I took a lot of guff over that. But it wasn't my fault. I have time to see each student in my caseload only once each semester. I must have seen her early in the semester, when she wasn't showing yet."

One reason detection is difficult is that students are often motivated to deny and conceal pregnancy. Many of the teenage parents to whom we spoke told us that even after they had accepted their pregnant status, they did not tell any school staff member. One remark reflected the views of many: "I never talked to teachers or counselors about anything personal before. Why would I start now?"

The detection difficulties created by students are exacerbated by widespread school staff views that they should not be looking for pregnancy and do not really want to find it. Said one staff member concerned about undetected pregnancies, "You don't see them if you don't want to. One teacher had two third-trimester pregnancies in his civics class and didn't even know it." Sometimes school staff do not want to discover pregnancies because they do not want to

believe student pregnancies occur. Others are motivated to avoid the extra work that might be involved when students assigned to them become pregnant.

In many schools, guidance counselors handle the pregnancy cases in their own already heavy caseloads. Most counselors we spoke to found this frustrating—they did not have enough time to really help the pregnant students, yet the time they spent with them left less time for other students. Many counselors complained that large caseloads (averaging 300 to 400) made the intensive one-to-one involvement necessary to counsel a pregnant student impossible. Most believe they lacked the training to do a good job at it. Their experience generally related to academic and vocational advising; they recognized that pregnant students often needed more personally oriented counseling. One counselor voiced a common thought: "I'm an academic advisor, not a therapist. I'm not trained to do this. And I don't want to." Regular teachers often shared this view.

In some schools that still have full-time nursing staff, the nurse is expected to be responsible for handling student pregnancies. Their situation is in many ways similar to that of counselors: The press of other duties and a lack of training in psychological counseling may cause them to feel unable to be of much help. In a few cases, nurses were never formally assigned responsibility for pregnant students; these nurses resented the unacknowledged imposition of additional duties that counseling of pregnant students entailed.

Another important factor in the reluctance of school staff to discover pregnancy at an early stage is the general opinion that pregnancy resolution decisions are a personal and family issue, and not something in which the school should participate. Discovering pregnancies late (usually in the second trimester) allows the school to avoid any but the most peripheral involvement in these decisions. However, by being uninvolved, the school abrogates any chance to encourage students to consider the educational implications of these decisions. As discussed in Chap. 5, these considerations are almost always deferred until after a pregnancy resolution decision has been made.

In most schools the person "in charge" is expected to take responsibility for calling the student in, discussing the pregnancy, and making appropriate referrals for needed services, including the special program. In a few schools we visited the contact person is expected only to be available, with contact remaining the pregnant student's responsibility.

Staff in middle-class schools are especially likely to leave the initiative to the student herself. Said one respondent, "Most of them have family doctors and know what's going on. Their families take care of it." A nurse in one middle-class school mentioned that the previous year a student remained in regular school until her seventh month of pregnancy without being contacted by any school staff member. "We're reluctant to intervene because we don't want to appear to meddle in their (students') personal business."

In one district, neither school site policy nor extant norms require staff outreach when pregnancy is suspected. A teacher who suspects pregnancy may or may not tell the counselor or school nurse. On learning of a suspected pregnancy, a counselor may not call a student in; the school nurse generally gives the student's name to the nurse in the special program who does try to contact her. These practices carry to an extreme this district's policy of not treating pregnant students differently from other students. The policy of "treating everyone alike," as explained by the superintendent, involves an honest attempt to offer every student the best possible education. It does not mean that special needs should be ignored. Indeed, this district has made a strong commitment to pregnant students and teenage mothers by providing a supplementary curriculum program that includes child care. District-level staff support the superintendent's belief that the LEA is obligated to eliminate obstacles to schooling for every student. Yet the superintendent's message has been distorted at the school level in a way that may limit opportunities for pregnant students. Our fieldwork data suggest that this LEA has

a good program that suffers because regular school staff are not active in making referrals to it.

In a number of other LEAs, regular school staff are similarly reluctant to initiate contact when pregnancy is suspected. In one LEA, part-time school social workers are available to follow-up on school staff referrals, but referrals often are not made. District administrators are aware of the problem but have not intervened, believing that individual schools have the right to establish and implement their own procedures. Several school staff respondents attributed their passive stance to Title IX. Said one counselor, "According to Title IX, we aren't supposed to treat pregnant students any differently. Calling in a girl because we think she's pregnant would violate Title IX, so we don't do it."

Given such reluctance on the part of both school staff and students to confront pregnancy, cases often fall through the cracks. Many respondents acknowledged that pregnant students may drop out well before the school is aware of it. Students may say they are moving or getting a job; if they are over age, they are rarely followed up. Students known to be pregnant may also drop out early in the pregnancy. Even if under age, pregnant or parenting students are rarely pursued with vigor. In some LEAs, this practice reflects state laws defining pregnant or parent students as emancipated. In other cases, it reflects the low probability assigned to their return. In every case, it reflects the schools' generally acknowledged inability to pursue potential or actual dropouts of any sort because of lack of personnel and funds for this time-consuming effort.

In one LEA we visited, four people in each high school—the dean, nurse, counselor, and social worker—may appropriately work with pregnant students. Yet many pregnant students in this district reported to us they had not discussed their pregnancy with any school staff member. No one had contacted them to discuss schooling options, health care, or any matter whatsoever regarding their condition. Several factors account for this phenomenon. In this LEA, neither the district nor individual schools have a policy that teachers must report pregnancies. Teachers therefore may not reveal that they have heard rumors of a pregnancy. Even if they wish to tell someone, it is not clear whom to tell. School counselors are responsible for academic programming; neither school staff nor students regard them as personal counselors. The dean of girls, who does some counseling, is mainly responsible for discipline. School social workers, despite their title, are mainly responsible for attendance, acting much like the "truant officers" of old. The nurse in each school was near retirement age and was very much aghast at student pregnancy. Several students complained that there was no adult at school in whom they could comfortably confide. When asked about improvements the schools could make in handling student pregnancy, these students asked for a "real" counselor.

### Counseling

When counseling occurs in regular school, it is usually a brief process whose goal is often to encourage the student to enroll in a special program. If an inclusive curriculum program is available, motivation to encourage transfer is strong, because then the regular school need not be involved again until after delivery. If the special program is located on campus, enrollment motivation remains, because then special program staff will assume responsibility for counseling and services for which regular program staff feel unqualified and too pressed to provide.

Counselors and nurses generally agree on the goals of a counseling session with a pregnant student:

1. To determine that the pregnancy has been clinically confirmed.
2. To ensure that the parents have been informed of the pregnancy.
3. To check on whether prenatal care has been initiated.[3]
4. To inform the student of available educational options.

In cases where a pregnancy confirmation or a resolution decision has not been made, a referral may be made to Planned Parenthood or a similar agency that provides counseling and services (including abortion).[4] Or the student may be referred to the special program counselor.

School staff are more willing to be involved in decisions about schooling. This is their area of expertise, and is free from the heavy emotional concomitants of pregnancy resolution decisions. Nearly all of the schooling decisions in which school staff participate concern *where* and how to attend during pregnancy, but not *whether*. Students ordinarily decide whether or not to drop out on their own, or in conjunction with their parents early in the pregnancy, without involving the school. Those who decide to drop out often do so before the pregnancy becomes known, and may present a fictitious excuse for doing so.[5] As discussed in Chap. 5, the most important factor in the decision to remain in any school program is the student's own determination to continue and earn a diploma. The schools' generally passive stance toward pregnancy detection and their subsequent late involvement means that they usually play a negligible part in the school-continuation decision.

For continuing students, school staff we interviewed are often actively involved in schooling decisions and are willing to make a recommendation and push it hard. Said one school nurse, "I'll sell it (the inclusive curriculum program) or not, considering the girl's needs, level of achievement, etc." More than one student told us that a counselor or nurse had said that certain services, e.g., postnatal homebound instruction, were available only to inclusive curriculum program enrollees, when that was not true. In two instances in our sample, this misinformation led to transfer to the inclusive curriculum program.[6]

In some cases, school staff make decisions for students by leaving unfavored options unmentioned. For example, long-term homebound instruction, even when available, is rarely proposed. Counselors believe that lack of structure and social support, in addition to feelings of exclusion and loneliness, can have negative effects on academic motivation and school continuation. In many schools, there is also widespread reluctance to recommend to students that they remain in regular school, though usually but not always their right to do so is acknowledged. In almost every junior high we visited, pregnant students are expected to leave regular school as soon as possible, for their own benefit as well as for the benefit of other students. Said one junior high counselor, "Kids this age just can't handle it. They tease girls, whisper, and generally make them feel uncomfortable . . . and it really shakes them up." Said one junior high principal, "The girls are routinely informed of the option of staying in (regular) school or going on to (the inclusive curriculum program) with extremely heavy emphasis placed on encouraging the girl to transfer. Most girls choose to go to (the inclusive curriculum program)—probably 95 percent." He went on to say that in his school all pregnant students—regardless of achievement level or background—are counseled to go to the district's inclusive

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[3]Since detection usually does not occur before the second trimester, the pregnancy resolution decision has generally been made. Girls who decide to abort are rarely counseled by or even known to school staff.

[4]A number of counselors and nurses to whom we spoke were uncertain about whether they could or would make a referral for abortion counseling if a pregnant student lacked such information.

[5]For example, one counselor told us that under-age students often say they are moving. This reduces the chances that an attendance officer will pursue the case.

[6]This misinformation reflected general misinformation on this point among school staff. Several staff members in this LEA gave the same erroneous information.

curriculum program because it has the coursework and facilities a young parent needs. "It is not a place to shove the pregnant kids," he said, "although it may seem that way." Another junior high school principal was so eager to get a pregnant student into the inclusive curriculum program (which did not serve junior high school students) that he promoted her several grade levels. He felt justified in doing this because he is convinced that pregnant students are better off in an inclusive curriculum program where they receive relevant learning and feel more comfortable.

Sometimes school staff may influence a decision by presenting an option unknown to the student or her parents. For example, in one LEA in our sample, junior high counselors in white schools often mention that withdrawal from school during pregnancy can be accomplished with a doctor's note. Many white parents choose this option over enrollment in the inclusive curriculum program located in a minority area of town.

High school staff are not as uniformly determined to remove pregnant students from regular school, although counselors generally advise enrollment in an available inclusive curriculum program. Counselors acknowledge that the social costs of regular school attendance for pregnant students are lower in high school than in junior high, but stress that regular school attenders miss out on the services and special protection available in inclusive curriculum programs. A few counselors are insistent on transfer out. One high school interviewee told us that her counselor never mentioned regular school attendance as an option during pregnancy. However, she knew she could stay because "There are lots of pregnant girls in school. If they could be there so could I." (She stayed.)

Counselors' attitudes often reflect the views of principals and superintendents. One superintendent maintained that pregnant students should transfer to the district's inclusive curriculum program because "they do not fit into a (regular) high school setting." The principal of one high school in another LEA said he does not allow pregnant students to stay in regular school because of his concern about their safety in the halls and in the vocational shops.[7] Pregnant students are generally aware of such informal policies and staff attitudes. Respondents who had attended the high school run by this principal chose to transfer to the inclusive curriculum program largely because of his exclusionary policy. They told us students in this high school "just don't stay" in regular school during pregnancy.[8]

A few counselors believe that remaining in regular school is a preferred alternative for the pregnant student that also benefits her nonpregnant peers. For some nonacademically oriented students, involvement in art, drama, music, or other activities motivates school continuation. Transfer to an inclusive curriculum program would entail giving up these activities and would vitiate this motivation. Several respondents believe that pregnant and parenting students in regular school serve as a deterrent to youthful parenting. The multiple demands of schoolwork and childrearing and their dampening effects on an adolescent's social life causes other students to view early childbearing more realistically.

While counselors often push for transfer to the inclusive curriculum program, they may know little about it beyond its availability and phone number. Few in our sample had visited the program, and many had only a general idea of its curriculum. They did know that relevant learning was stressed, that student-teacher ratios were low, and that the atmosphere was protective. Several programs made outreach visits to counselors on a regular (usually yearly)

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[7]Several respondents noted that safety concerns are often a cover for a simple desire to exclude pregnant students. One principal noted that while safety is a valid concern in recommending transfer to the inclusive curriculum program, it is interesting that pregnant teachers often remain until almost term, negotiate stairs and hallways, and do all the things students are not supposed to be able to do.

[8]This principal's strong views reflected strong community opposition to visible pregnancy in regular schools.

basis. While counselors did not appear to learn a great deal from these visits, they generally felt they knew enough to refer.

Beyond such visits, little information about pregnancy is provided to regular school staff. In one LEA, regular school staff who were likely to have contact with pregnant students and teen mothers were provided a day of inservice training at the inclusive curriculum program site. Several staff members found this valuable, but it was never repeated. More commonly, any inservice training on this topic is provided only to special program staff, although most special program staff also receive no training.

Faced with a pregnancy and the press of other responsibilities, some counselors simply call special program staff to "come over and take over." Said one counselor, "The district puts its inservice training efforts into special program staff. They know what to do. We don't." Pressures to enroll in the special program, already strong, are no doubt increased when special program staff are actively involved in the decisionmaking process.[9]

It is not unusual for regular school staff to believe that the academic component of the inclusive curriculum program is weak. In one instance, counselors still pushed the program for everyone but urged students to return to regular school promptly after delivery. They told us that the monitoring of prenatal care and the relevant learning available in the program outweighed academic considerations during pregnancy. In another LEA, in which both an inclusive curriculum and noncurricular program were available, counselors often urged bright and motivated students to stay in regular school. In several LEAs, students who violated stereotypic staff views of pregnant teenagers as not caring about school were treated differently in being encouraged not to transfer.

### Transfer

Once a student agrees to transfer to an inclusive curriculum program, school staff transfer all responsibility for the student to program staff. Although the student is not allowed to stay for more than a year in 6 of the 7 inclusive curriculum programs we visited (and most stay for a shorter time), the regular school acts as though the student is leaving permanently. As with other types of transfer, all her records are sent to the program and she is dropped from her counselor's caseload. As far as the official records are concerned, the student leaves the school. Whether she reenters is thus not that school's business. On the informal level, plans for regular school return are seldom discussed. Rarely does a counselor suggest that a student call or keep in touch. The opportunity to build in an expectation of regular school return is simply not seized; the emphasis is on transferring out, and the time frame of concern is the period of pregnancy.

Whether the available option is an inclusive curriculum or noninclusive program seems to make little difference in school procedures for treating pregnancy. In all cases, regular school staff look to special program personnel to take responsibility for pregnant students. In the case of supplementary curriculum and noncurricular programs, counselors maintain the student in their caseload, but their involvement with pregnancy is limited to such matters as schedule changes necessary to accommodate a parenting or prenatal class provided by the special program.

In three of the five on-campus programs we visited, there was evidence of professional

[9]In two sites, enrollment in the inclusive curriculum program has been decreasing in recent years as more students choose to remain in regular school. Such decline may create pressures on program staff to "recruit," though they seemed uniformly committed to their program on humanitarian grounds.

jealousy between special program and regular school staff. In all three cases, the animosity stems from the belief by home economics teachers and nurses that special program offerings are detracting from the curricula already available to students in home economics or health classes. Special program staff say that this belief causes school staff to make fewer referrals to the program. In every case, special program staff have reacted in some way to minimize the problem. In one case, program staff campaigned carefully for acceptance by attending faculty meetings and other events. Special program staff in another school in the same LEA took note of the problems of their cross town-colleagues and withdrew a request to have the health unit they taught be credit-granting. Staff in a third on-campus program responded to the animosity by crouching further under their already low profile.

Principals at two of the schools involved are aware of the competition between regular school and special program staff, but have done nothing to encourage better working relations. Indeed, no one in these school systems accepted responsibility for integrating the on-campus programs into existing curricula or facilitating their acceptance by regular school staff. Formal responsibility for the noncurricular program in one LEA was given to the head of the school health program, who also supervised the inclusive curriculum program. This person, herself threatened by the noncurricular program, could not be expected to take (and in fact did not take) an active role in facilitating its acceptance and integration. The result was that some students who may have needed or benefitted from the noncurricular program were not informed of it or were presented distorted information that negatively influenced their decisions. Meanwhile, noncurricular and regular school staff lost the opportunity to work cooperatively to address problems of pregnant students and teenage mothers.

### Pregnant Students Who Stay

As the stigma attached to pregnancy decreases among teenagers, more students are choosing to remain in regular school through their pregnancies. (See Chap. 5 for discussion of the factors that pregnant students consider in choosing to stay in regular school.) However, few schools—particularly those in districts that have an inclusive curriculum program—have done anything to acknowledge or assist them.[10]

In general, the school's limited policies surrounding pregnancy-related activities come to an end at the point at which enrollment in the special program is recommended; few policies or procedures exist for working with a pregnant student past this point in a pregnancy. This lack of policy reflects a widespread conviction that pregnant students should not be on campus, that an available inclusive curriculum program can best meet their needs, and that a student's refusal to enroll in it shows her to be ungrateful and therefore undeserving of further assistance, or may indicate she does not need special attention. One teacher summed up these feelings in talking about a student enrolled in her class who "insisted" on staying in school and who was having difficulties keeping up: "Why isn't she in (the inclusive curriculum program)? That's where she belongs—it's *their* job to be understanding, not mine."

Any extra help or support pregnant students get in most regular schools depends entirely on the willingness of individual staff members to offer it. There is no administrative pressure or even expectation that staff will do anything special for pregnant enrollees. A notable

[10]When a student has enrolled in a noninclusive program, such as Program K (described in Chap. 3), regular school staff correctly assume that many of the student's needs are being met by the program. Regular school staff still have a role to play, e.g., in helping a student to keep up her coursework, in modifying her schedule as needed, and in providing encouragement and support.

exception is one school where some counselors make it a point to see a pregnant student two or three times during her pregnancy. Most counselors do not, however. Students who come in *asking* for help may or may not receive it. One counselor told us that if a student comes in asking for any kind of help, she immediately suggests transfer to the special program. Most counselors are more obliging. In one school, a free first period is typically offered to pregnant students and teenage mothers so that they will have extra time in the morning to get to school. Students in this school who were doing well prior to pregnancy may be permitted to do some "independent study" coursework at home; those who had already earned extra credits may be offered a reduced day schedule.[11] When asked either by a student or a counselor to make special accommodations, most teachers will do so, though often with some resentment. That resentment may be understandable. One respondent, a home economics teacher, told of a request from a counselor to prepare assignments for a pregnant student who had enrolled in school, attended two days, then dropped out to have her baby. Although the teacher complied, she did so reluctantly: "It was annoying to have to do it because it was an unrealistic request. She (the counselor) knew very well the girl would not do the work."

Students report that the responses of individual teachers run the gamut. Without any policy, teachers may treat different students quite differently: Several respondents at one high school reported that a particular counselor had gone out of her way to be helpful; others reported that she gave them no help at all. A very few teachers may respond to the pregnancy by relaxing their requirements. Said one interviewee, "I finally had to tell my math teacher to stop being so easy on me—she was giving me less homework than the other students." However, most teachers ignore pregnancy. Unless the student asks for makeup work, deferred grading, or other special treatment, the teacher typically does nothing. According to some respondents, teachers often protect themselves against having to do anything by not even "seeing" the pregnancy.

Students reported a few instances of negative comments and unpleasant behavior from regular teachers. Two respondents told us that in the later months of their pregnancies, one teacher called on them to recite in front of the class more often than other students. A few teachers privately expressed their disapproval of the pregnancy to the students. Far more common, however, was the "strict equality" doctrine summarized by an English teacher: "I have the same expectations for a parent as I have for a nonparent," she said. These remarks were generated in her discussion of a pregnant student who was often tardy to her class because of morning sickness. The teacher told the student she was welcome to come to class, but if she could not come for the entire session, she was not to come at all.

PE teachers as a group are most aware of pregnancy, and often have a personal policy about how pregnant students are to be treated. Ignoring pregnancy is obviously more risky in physical education classes, and all PE teachers we interviewed looked for signs of pregnancy. Nearly every one required a doctor's consent for continuation in a regular PE class, whether or not it was required by school policy. Some will not permit regular PE class participation in any case. A few PE teachers have pregnant students read about pregnancy or do supervised exercises during PE period, most have these students keep score or help in other ways. One teacher arranged for students to take a relevant elective, e.g., family living, during PE periods

[11]In this school, the principal had established a policy whereby a "team" composed of appropriate staff, e.g., counselor, nurse, teacher, met whenever a "problem" of any kind arose. A copy of the recommendations the team developed was sent to (and read by) the principal. Although no formal policy existed in this school concerning treatment of pregnant students, the principal's message that school staff were expected to be actively concerned with "problem" students was not lost on staff.

while pregnant. One unusually supportive PE instructor had pregnant students "dance through their pregnancies."

The dominant feeling among school staff—that pregnancy is not a school problem—is not lost on students. Most expect little from school staff in the way of sympathy or support. Said one teenage father who lives with his wife and two small children, "I haven't told any of my regular teachers that I have two kids. Why should I? They are real negative about early pregnancy and marriage and it wouldn't help me any." He recounted a time when he had been absent several days because both children were sick. The dean put him on probation for having too many absences, and was uninterested in the fact that his children's illness kept him home.

## POSTDELIVERY POLICIES

The postdelivery problems of students in regular school are at the same time more difficult and simpler than the problems they encountered during pregnancy. With the delivery of the child and the assumption of parenthood, their situation becomes socially invisible. The mother is once more physically indistinguishable from her peers. In districts with inclusive curriculum programs, students must return to regular school shortly after delivery. Both of these factors figure importantly in the attitudes of school staff: Once it is invisible, parenthood status can become a nonissue. At the same time, the fact that students have no choice but to leave the special program tends to make staff somewhat more sympathetic: Parenting students are not refusing help or flaunting counternormative behavior by being in regular school.

Generally, parents have more problems staying in school and keeping up with their nonparent peers than do pregnant students. Child care must be arranged, children fall ill and, if financial support is not provided by family members, a parent may be working to meet basic expenses. All of these problems are chronic.

Parenthood is a much less salient issue to school staff than pregnancy, however. In our interviews, the period of pregnancy was highly salient, while parenthood was often ignored. One reason was that many school staff believed that participation in a special program during pregnancy adequately prepares students to return to regular school and successfully fulfill both student and parent roles. A second is that the invisibility of parenthood allows it to be ignored more easily than pregnancy. Many districts and schools have policies that intentionally or unintentionally reinforce invisible parenthood, e.g., parents are not allowed to bring babies on campus; transfer records do not identify the special program or pregnancy as the reason for transfer.

The head of an inclusive curriculum program was upset that the schools did not follow up on the efforts the program had made. "They make no concessions in terms of curriculum and make no efforts at all to provide needed services such as parents' groups." Said a program head in another site, "The single most unifying trait of teenage mothers is their passivity. Many can't ask for help. If that's what they have to do to get it, they do without." Students who leave school to attend inclusive curriculum programs are generally agreed to be the most shy, timid, and passive of pregnant students as well as the least committed to education. The period following their return from the inclusive curriculum program may be very difficult, yet help is rarely offered. Staff in most sites say that many students drop out during this time.[12]

In many schools, the "policy" for student parents is to do nothing unless a student asks, and even if she does ask, support may not be forthcoming. Some staff believe that a teenage

[12]These views are consistent with research (e.g., Klerman and Jekel, 1973) which indicates that the first-year postpartum is a common dropout point among students who remain in school throughout pregnancy.

mother has no right to be in regular school if she is unwilling or unable to do her work on time without extra assistance. One young parent who was attending the district's vocational high school told us she was referred there when she had trouble getting to her regular high school on time. She felt she had been mistreated: "Working students in (regular) high school can arrange flexible class schedules, but flexible scheduling wasn't offered to me." Many staff members told us that they are willing to do a great deal if asked, but students rarely ask. An occasional student is so bright and so contrary to staff stereotypes of student parents as unmotivated and dull that staff approach *her* about a college preparatory curriculum; another student is so likable and gregarious that she makes friends with staff and they go out of their way for her. But these are exceptional occurrences.

One district we visited had established a policy designed to ease the postdelivery transition to regular school. In this LEA, a pupil placement committee composed of the student, her parent or parents, a school social worker, a representative of the regular school, and a representative of the inclusive curriculum program meet with the pupil personnel director prior to transfer out of the program. In this meeting plans are made to ease the transfer and the kinds of support the student can expect to receive from her counselor and school social worker are discussed. This meeting serves to establish that the student is *expected* to return. Her records are transferred at this time.

For some students, problems may occur because return is required before they are really ready to leave the security of an inclusive curriculum program. Every such program in our sample has a policy that specifies when a new mother must return to regular school. Some of these policies allow some discretion, others do not. In one program that serves several LEAs, district policies concerning return and reentry range from very inflexible to highly flexible: One district will waive the requirement that an enrollee leave the special site program at the first marking period after delivery if the program director believes that she would benefit from a slightly longer stay; another district follow the rules on return to the letter. According to the special program director, more new mothers from the flexible district ultimately return to regular school.

Even minor help can ease the transition and reduce role strain considerably. For example, a first-period study hall gives parenting students precious time to get the baby to a child care center or sitter without being marked tardy. This practice is fairly common, probably because it comes within the bounds of "academic advising" of the sort counselors generally see as part of their job.

Most parenting students need more, however. On-campus programs usually provide parent groups to discuss problems. Other noncurricular programs often help teenage mothers to find child care, housing, and other needed services. Supplementary curriculum programs with child care labs provide a service of immense value to some parents—not only child care, but hands-on parenting courses that include a great deal of personal support.

## STAFF ATTITUDES

Policies may serve to override attitudes, but more commonly reflect and reinforce them. When policies are informal and casually enforced, attitudes dictate policy. The fact that policy regarding the treatment of pregnant students and teenage mothers is not strongly enforced or does not exist at all in regular schools allows staff attitudes about student pregnancy and parenthood, and about the appropriate role of regular school staff, to dominate. Many educators visualize pregnant and parenting teenagers as academically marginal, low-achieving, low

income, and usually minority students who might have completed high school without a pregnancy, but only through luck, inertia, and the general tendency of public schools eventually to graduate everyone who shows up for classes.[13]

This view is especially prevalent among superintendents and principals. For example, one junior high school principal said, "A diploma will make no difference to these girls," suggesting that they might well have dropped out of school for a number of other reasons had they not become pregnant. Several other junior high school principals shared this conviction.

Most staff believe that, whatever the initial capability of a pregnant student, becoming a parent will inevitably vitiate her educational and vocational success. They view her as having made a mistake that "wastes" her potential; consequently, many do not want to invest a great deal of effort in her. While interviewees were clearly reluctant to acknowledge it, it was evident that more than a few of them regard a teenage pregnancy as a moral violation, and are unaccepting and unsupportive. Counselors believe that older faculty in particular have such attitudes, while young liberal teachers are more positive and helpful. One nurse suggested that male educators tend to be "more judgmental," while another nurse believes that males are more tolerant. While determinants of differential staff supportiveness could not be established given the small number of interviews, it was clear that visibly pregnant teenagers have a negative social identity in the eyes of some school administrators and regular staff, who may regard them as morally inferior as well as intellectually and socially disadvantaged.

Besides being inaccurate, these assumptions have had two negative influences on counseling and services in most schools. If a student actually matches the stereotype in some respect (e.g., income, ethnicity, or achievement record), she may be treated as a sociological inevitability and may not receive serious individualized guidance. For example, she may be plugged automatically into the social service system, the system will casually accept the idea of her becoming an unwed welfare mother, and she will not be provided with adequate counseling about alternative options and decisionmaking with respect to educational and occupational goals. She is seen as merely one more instance of a general subcultural phenomenon. On the other hand, if a student falls outside the stereotype, there is denial and shock: Nobody is prepared to respond to the situation reasonably; all social and counseling services have been oriented toward quite a different population. In either case, the stereotyped social identity of the pregnant student vitiates her options.

School counselors and school nurses tend to have a more accurate view of the pregnant student, regarding her as not inherently different from the rest of the school's population. The individuality of the cases was stressed by these interviewees. One junior high school counselor said that some pregnant teenagers really "need something to love," and others "got caught fooling around." Another pointed out that some are low-achieving and some high-achieving, some are social isolates and some popular, some are rowdy and others quiet and serious. Said one director of pupil services, "They range from the college-bound to the potential welfare mother." All agreed, however, that the fact of pregnancy would have a serious impact on their subsequent social identity.[14]

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[13]Such stereotypes are encouraged by a number of factors: (1) Most data related to teenage pregnancy and parenthood have been collected from inner-city minority samples. (2) There is a higher incidence of abortion among upper-income white students, so that visible or reported pregnancies overrepresent minority teenage pregnancy. (3) Everyone would prefer to believe that teenage pregnancy does not happen to "our" kind of people, it happens only to "them."

[14]A number of studies point to the heterogeneity of teenage parents. McHenry, Walters, and Johnson (1979) note that while illegitimacy does follow a generational pattern it often occurs where no such pattern exists, calling into question the idea that pregnant adolescents are a "special group." Chilman (1979) cites several studies that find more similarities than differences between those who later became premaritally pregnant and those who did not. Chilman

Staff attitudes about teenage fathers are mixed. Some staff decry the double standard under which fathers are not considered jointly responsible, and encourage the involvement of the father-to-be in planning for the baby whenever possible. Most simply surmise that, although little is known about the fathers, they probably need some guidance. For many, the father is simply out of the picture. Occasionally, staff may act to ensure he stays out. One teacher told us of a colleague who counseled an alleged father-to-be not to get involved with the pregnancy. He suggested that it was bad enough that his girlfriend had ruined *her* life; there was no reason for him to do so as well. One teenage mother we interviewed reported that she had been "hassled" by teachers because her boyfriend had given up college plans (at least in the short term) in order to earn money to support the baby. Interestingly, staff members who regard teenage parenthood as a moral violation tend not to extend these views to fathers. For instance, while a substantial minority of respondents thought that mothers should not be in regular school, no one voiced the same opinion concerning fathers.

Attitudes toward parents are varied. Most school staff agree, however, that those who return to school after delivery have changed in a positive way. Respondents told us mothers are more modestly groomed, more academically motivated, and generally "more together" than they were before delivery. In many sites respondents told us that students who return from delivery earn better grades and are often caught up academically. Several attributed such effects to the support received in the special program, and students concurred with these views. Teenage mothers often described themselves as more serious about school. Parental responsibilities left them less time to squander, and many had acquired a sense (for some, for the first time) that school is important because they would soon have to work to support their child. Said one mother, "It's hard enough to get a good job with a high school diploma. It would be impossible without one." Students generally attributed their more mature attitudes to the fact of being a parent and to their baby's dependence on them for financial and emotional support.

In spite of general agreement that delivery is a maturing experience, school staff disagree about mothers' future prospects and the appropriateness of their reenrollment in regular school programs. One common approach is to extend feelings about pregnant students to parents, seeing them as academically marginal and, given the added burdens of parenthood, unlikely to succeed in a regular school setting. Some believe that parents do not fit socially or psychologically in a regular school. In their view, the experience of pregnancy and parenthood leaves students more sophisticated, more sexually knowledgeable, and more interested in adult concerns. Such students were said to regard the amusements and concerns of adolescents as silly and frivolous.

A contrasting view often held by counselors and nurses is that the returning student parent brings an enhanced academic potential with her. That is, such students were not marginal at the outset, and the individualized attention they received during pregnancy often enables them to achieve above the level at which they left (the latter point was disputed by no one). Further, because of being mothers, they often have greater incentive to do well than before and have a more realistic sense of educational and occupational aims than their peers. Even for the highest-achieving students, however, the demands of parenthood often impose insurmountable obstacles to continuation in regular school. Counselors and nurses emphasized that these problems were not intrinsic but extrinsic; if, for example, a child care center were attached to

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notes that while some psychological differences might well exist, at least some nonpregnant adolescents remain so only because of luck or subfecundity. Klerman and Jekel (1973) note that in their sample of young mothers, which was homogeneous in terms of demographic and socioeconomic background, there was a wide range of achievement and life style.

the school, and teenage mothers were routinely offered support, the picture would change dramatically. But the widespread belief that teenage parents are marginal, combined with feelings that parenthood is a "mistake" outside the concern of the school, weakens efforts to establish policies and services that might promote and maintain attendance.

A few school staff had no opinion at all about teenage mothers and reported no known experience with them.[15] One student who returned to regular school after delivery went to her counselor to discuss attendance problems. He was unaware of her frequent absences and did not know she was a mother. For a variety of reasons, school staff may not know that a particular student *is* a parent. Transfer policies that have students leave school on an apparently permanent basis (like any other transfer) result in no expectations or preparation for return. Early departures to an inclusive curriculum program, combined with reasonable concerns for privacy, may mean that staff are unaware of why a student transferred out and back in. Denial and lack of interest on the part of staff may also play a role. Students often contribute by their reluctance to reveal they have children.

The dominant attitude of staff in most schools is that pregnancy and parenthood are primarily problems of the female student and her family, and therefore they (not the school) should initiate information-seeking and decisionmaking. School staff are willing to make reasonable efforts to help such students cope with what they see as a mistake, but they are generally unwilling to invest a great deal of extra energy in students who have narrowed their options; they would rather expend their efforts to help nonpregnant and nonparenting (that is, nonproblem) students first.

These attitudes contribute to the essentially passive operations and procedures we found in most schools for dealing with student pregnancy and parenthood. Staff feel little responsibility to inform themselves about the special program or other options, or offer help in an active way. It was not unusual to hear stories from special program staff or students about regular staff apathy. For example, one student attending a high school that offers a supplementary curriculum program told us that it was *she* who told her counselor that he could enroll her in the program's prenatal class instead of study hall; he had not recommended it.

Staff members in many schools commented that information and guidance are available to pregnant students and teenage parents if they ask for it—if they are self-starters and initiate the process. But those who are shy, less socially competent, or less motivated—those most in need of help—are not likely to get it because the schools have not developed the procedures or personnel to provide it. Said one respondent, "The weakness of most counseling at the high school level is that unless kids call attention to their problems, the counselor does not offer help."

Given staff attitudes plus lack of active support and clear policy in the regular school, the needs of pregnant and parenting students for educational counseling or other services are likely to go unmet. Moreover, if such students believe the school has no provisions for dealing with pregnancy and parenthood and no help to offer, they might reasonably be reluctant to risk exposure to negative attitudes by contacting staff members or officially involving the school in their situation.

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[15]That this occurred at all in our sample, when we asked to meet with staff members who had had contact with pregnant students and teenage mothers, suggests that lack of known contact may be common in the population of regular school staff.

## CONCLUSIONS

Response to student pregnancy and parenthood focuses almost exclusively on special programs in the school districts we visited, despite the fact that the regular schools influence the educational careers of pregnant students and teenage mothers (even if by default), and could play a crucial role in assisting them. At several points, the regular school could intervene to increase the likelihood that pregnant students receive medical care and continue in school, two actions considered desirable by all our respondents. These points include:

- Pregnancy detection. Early detection would give pregnant students time to carefully consider pregnancy resolution options. For those who choose to deliver, an early decision could mean that prenatal care is begun at an earlier time. As it is, late detection, frequently combined with denial of pregnancy on the part of the student, means that abortion is not an option and that prenatal care in the first months is frequently forgone.
- Pregnancy resolution decisionmaking. Nearly all regular school staff believe that the school should have no role in pregnancy resolution decisions—that these are decisions for the student and her family to make. Complete uninvolvement of the school may, however, result in decisions made on the basis of incomplete or inaccurate information. As discussed in Chap. 5, pregnancy resolution decisions are rarely made with any consideration for their educational implications. Some involvement of school staff members early in the pregnancy might encourage students to consider the educational implications of the options they are considering. Provision of information regarding school programs might be particularly helpful.
- Support for school continuation among transfers to an inclusive curriculum program. Such support is often limited to a strong recommendation to transfer to the program. No efforts are made to follow up on a student's progress in the program, to coordinate her academic program, or to let her know that someone at her regular school expects her to transfer back after delivery. This latter point is critical since, as many respondents noted, dropouts are particularly likely to occur after delivery, often in the process of transfer back to the regular school.
- Services to pregnant students in regular school. The growing numbers of students who elect not to transfer to an inclusive curriculum program can expect little support from regular school staff. Virtually no schools in districts with inclusive curriculum programs provide special services to pregnant students; few have any policy or procedures that extend past the point at which a student is "supposed" to transfer out. Those attending schools with on-campus programs do receive special services from program personnel, but can expect uneven treatment from regular school staff.
- Services to parenting students. Integrating the roles of parent, student, and teenager may not be easy. Even the most motivated may fall behind or drop out because of unreliable child care, illness, or financial difficulties. Yet because parenthood is far less visible than pregnancy, school response is often very limited. Attitudes among some staff members that mothers should not be in regular school settings contribute to a climate of inaction and passivity. The enormous efforts and resources provided to a student by an inclusive curriculum program during pregnancy seem to evaporate once she delivers and returns to regular school. Much may be done if a student asks for help, but little is provided if she does not.

The importance of the regular school is likely to increase as more students choose to remain in regular school throughout their pregnancies. These students cite the advantages of remaining in a diversified, high-quality academic program and staying with friends as major factors in their decisions not to leave. The reduced stigma of pregnancy among their peers allows them the freedom to make this choice.[16] Inclusive curriculum program staff everywhere have noted the increasing numbers of "stayers" and the need to provide them some services in regular schools.[17]

Yet provision of such services receives limited support for a variety of reasons. Many believe that the inclusive curriculum program is a sufficient school response to student pregnancy; students who reject the program have no right to expect expensive duplicate services at regular school sites. A few support the inclusive curriculum program because it removes pregnant students from the school. Obviously, on-site services would not be acceptable to this group. More commonly, resistance can be found among regular school staff who contend they simply cannot handle another "problem." Many see "problem" students as outside their roles as teachers and advisors; even those who are inclined to be helpful cite lack of time and training.

The lack of regular school response to student pregnancy and parenthood often reflects district-level policy. For example, in many LEAs pregnant and parenting dropouts, even if under age, are not followed up. In spite of state law to the contrary, attendance officers often consider such students "emancipated."[18]

Help and support may be available in regular schools, but it is provided on an individual basis. As a result, it varies enormously as a function of both giver and receiver. Very bright and personable students told us of many helpful actions that school staff initiated; those less favorably endowed had to ask for help, which was sometimes forthcoming and sometimes not; some did not ask for help, and therefore received none. As many respondents noted, teenage parents are often passive. Many would quit school before they asked for help in staying. Not asking may seem a perfectly rational course. If help to that point had been provided exclusively by special program staff, what reason would a student have to think regular school staff would be responsive?

## RECOMMENDATIONS

### More Regular School Involvement

A major barrier to serving the needs of pregnant students and teenage mothers is a widespread conviction among regular school staff that pregnancy and parenthood are the student's, not the school's, problem. Simply raising the issue in faculty meetings would do a great deal to legitimize school involvement. Presentation of data on school-site pregnancy, including the number of pregnant and parenting students currently in school, and the number who drop out, transfer, return, and the like, would clarify the dimensions of the problem at the school site. A statement by the principal that staff are expected to respond, even without establishment of specific policies, would be useful. Establishment of specific policies would be even better.

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[16]See Chap. 5 for further discussion of school career decisions.

[17]In several LEAs we visited, students who stay in regular school are allowed in theory to use inclusive curriculum program services, but rarely do so because of scheduling and transportation problems.

[18]See Chap. 1 for discussion of state and LEA policies.

Statements by the principal of one school that staff are expected to actively engage in helping efforts were effective there; in another, school "teams" that report to the principal sit down with pregnant students and teenage mothers to address schooling problems. Although these teams do not include community agency representatives, their inclusion would be beneficial. Such a team could establish ways to provide the best mix of counseling and services so that the student could make maximal use of existing school *and* community resources and attain the best possible outcomes.[19]

### Increased Prevention Efforts

Respondents everywhere noted the need for broader, better, and more relevant sex education in the schools, including explicit education about sexuality, pregnancy, and pregnancy prevention. A number of respondents believe that a good sex education curriculum should include discussion of norms and assertiveness training to help students consider the option *not* to have sex. Assertiveness training would also be useful in addressing more fundamental problems, such as lack of self-esteem. Said one respondent, a special program director, "Girls need to realize that they can make it in this world without being the girlfriend of some guy." Respondents in several sites also pointed out the desirability of improving the school's decision-skills curriculum, a change that would benefit all students and be well within the school's appropriate function. High school students typically do not have much experience in decision-making, and have no concept of it as a process that should be subjected to rigorous evaluation. On the other hand, we encountered widespread suspicion among school staff about the value of existing decisionmaking or values-clarification curricula. They had no concrete suggestions for how to teach decision skills, but most agreed that if the school is going to maintain that important life decisions such as pregnancy resolution are entirely up to the student involved, they are obligated to teach the student how to make them. One respondent, a Planned Parenthood staff member, argued that the schools' policy of leaving decisions about managing pregnancy and parenthood strictly to the individual is unrealistic—it means that major life decisions are left to individuals who, prior to pregnancy, may "have not even been allowed to pick out their own school shoes by themselves."

More than one respondent suggested that instruction in such volatile and politicized topics could best be provided with the least fallout by nursing staff employed by the department of health rather than by the school board. One nurse who made this suggestion is herself a health department employee. She believed this improved her sense of professional identity, helped her stay in closer contact with the health community, and freed her from some of the constraints on counseling and referral that often hamper school personnel.[20]

### Staff Inservice Training

A number of interviewees suggested there should be inservice training for regular staff since many of them may wittingly or unwittingly be in contact with pregnant teenagers. Such

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[19]For some students, welfare offices and vocational training programs might be represented on the team; for others, health and legal services; and others might need college-preparatory guidance. Program K, described in Chap. 3, closely follows this model and does seem to be helping students to receive needed services.

[20]As discussed in Chap. 3, Model Program L employs nurses funded by nonschool sources. As they are not school employees, school administrators do not feel responsible for their actions, and they feel freer in counseling about contraceptives and abortion than school nurses typically do.

training should be highly focused. First, especially at the junior high school level, it is important to make teachers aware that pregnancy does occur among very young students and train them to recognize pregnancy signals: such actions might promote early detection and referral to medical and counseling services. Second, teachers should be provided with current accurate information about the legal status of pregnant teenagers (e.g., the legality of receiving medical services such as pregnancy tests without parental knowledge) and about agencies to which such students can be referred for assistance.

Third, school staff should be informed or reminded that equal educational opportunities for and nondiscrimination against pregnant and parenting students have a strong legal basis. School staff were generally ignorant and sometimes misinformed about Title IX of the 1972 Education Amendments and its implications for parenting students.[21]

Fourth, staff should be informed in some detail about the district's special program for pregnant and parenting students. Additionally, other schooling options, both within and outside the school district, should be discussed. Many school staff that we interviewed knew little about the district's special program, and often were unaware of excellent programs run by nonschool agencies that included an educational component.

Inservice training is likely to meet considerable staff resistance. Most teachers and counselors to whom we spoke do not believe that such training is necessary. Home economics and physical education teachers generally felt they knew enough about pregnancy; other teachers and counselors often said they were not interested—that such training would be a waste of time and money; junior high staff said the incidence of pregnancy in this age group did not justify such training.

### Better Counseling for Parenting Students

Many respondents stressed the necessity of more active and continuous counseling for pregnant and parenting students. Most recommendations focused on counseling in early pregnancy. Respondents generally agreed that first, teenagers need better counseling about options for dealing with their pregnancies, because seldom are all alternatives mentioned. Second, students tend not to take school concerns into account until all other decisions have been made; it would be much better to confront pregnant students with the realistic interrelationships among decisions about pregnancy, parenthood, school, and employment at an early point in the decision process. Third, students are either not fully informed of educational options or else no option but the inclusive curriculum or other special program is presented as feasible. In many cases, no effort is made to encourage pregnant students to think about staying in regular school, let alone to promote that choice. Fourth, when referrals to nonschool agencies are provided, no attempt is made either to follow up on them or to coordinate school and community activity on behalf of the pregnant teenager. These gaps should be covered, as a minimum.

Conduct of a reentry counseling session for students returning to school from home instruction, dropout, or the inclusive curriculum program seems an obvious but often undone action. This session could be used to make scheduling changes and discuss educational options. Several followup interviews might be scheduled the first semester to check on problems and progress.

A number of respondents suggested that counseling could best be provided at the regular school site by a designated counselor who wants to work with pregnant students and teenage mothers and who has received specialized training to do so. A reduced caseload would facilitate

[21]See Zellman (1981) for further discussion of this issue.

more intensive counseling than is currently provided.[22] This special counselor would be expected to stay in contact with students who have transferred to an inclusive curriculum program in an active effort to get them back into regular school soon after delivery. One counselor maintained that personal, sincere insistence on school return is often the most important factor in preventing postdelivery dropout. He believes that dropouts are persuaded that the school does not care whether they continue or not and does not think them important as individuals. Active concern is therefore critical.

A "special" counselor position has merit, but unless part of the job includes keeping regular staff and the principal aware and involved, it may simply be used as a way to absolve everyone else in the regular school of any responsibility for pregnant and parenting students.

### Child Care

While the majority of respondents do not regard care for infants as an appropriate school activity, special program directors and many nurses and counselors believe that it is crucial to keeping mothers in school. Child care may make school continuation a possibility for a subset of mothers who cannot rely on family members to provide this service and who live in communities where very limited facilities exist for the care of infants. Child care also provides an incentive for school completion for some mothers who would not be willing to be separated from their infants for a long period each day. If on-site child care were not available, these mothers would leave school, at least temporarily. On-site child care also reduces the logistical burdens of school-motivated mothers who would otherwise have to take their child to a separate center (usually by bus) before coming to school each morning. These problems are often considerable and usually underestimated by school staff. For example, in one LEA students may use the inclusive curriculum program's child care center while enrolled in regular high school. Practically speaking, this option exists only on paper; a mother would have to travel for more than an hour each way on public transportation to implement this arrangement. Although students often consider their own mother as the caretaker of choice, given that they must complete school, their mother is not always willing or able to sit.[23] Some acknowledgement by the schools of the need for child care, either through direct service or help in arranging child care in community facilities, seems essential.[24]

### Flexibility

Many respondents regard flexibility in the treatment of teenage parents as critical to their success in school. Although they agree that academic standards should be maintained, sympathetic respondents are in favor of relaxed rules regarding absences, tardiness, and course loads, provided the student is making regular degree progress and fulfilling all assignments. The next best thing for students who cannot remain in regular school, respondents said, is arranging a flexible afternoon program—with a degree-oriented night school the third alternative. (A night

[22]The physical location of a special counselor must be treated with care, since students may not seek help if by so doing they are labeled as pregnant. In one site such a privacy problem was solved by arranging for the special program to share a waiting room with the school nurse.

[23]As women remain in or reenter the work force in increasing proportions, they are becoming less available as a child care resource.

[24]This latter approach, used by Program K (see Chap. 3), has successfully located child care for teenage mothers in a community in which little such care is available.

program was less favored because it separates the teenage parent from peers.) Ensuring that pregnant teenagers earn a diploma and have good access to postsecondary training if they need and want it is a reasonable school goal. Above all, respondents regard it as vital that these students not unduly restrict their horizons in relation to post-secondary training.

## Conclusion

The number of pregnant and parenting students in regular schools is likely to increase in the future, as more students choose to remain in regular school throughout pregnancy. Even if they attend an off-campus program during pregnancy, many return to regular school after delivery. Neverthelesss, school districts have generally ignored regular schools and the role they might play in helping pregnant students and teenage mothers complete school, in favor of developing special programs, many of them confined to the predelivery period. A workable partnership must be developed between special program and regular school staff to serve pregnant students and teenage mothers and improve their educational outcomes. And in this venture, the regular school must relinquish its role as a silent partner.

## Chapter 5

# TEENAGE PARENTS' PERSPECTIVES ON SCHOOL AND PARENTING

How many students are mothers and how many stay in school is a matter of opinion rather than fact in most districts. Most LEAs keep no statistics on dropouts by reason for termination; in the few LEAs that keep no such figures, most respondents, including those responsible for collecting them, doubt their validity. Formal records of pregnancies are not kept anywhere. In the absence of valid data, school staff opinions vary wildly: Estimates of the percentage of pregnant students and teenage mothers remaining in school ranged from 10 percent to 90 percent in one district.

Estimates of dropout rates among young parents seem to depend heavily upon the respondent's place in (or outside) the school system. For instance, superintendents and principals typically give high retention figures; special program heads and informed outsiders tend to guess low. High figures may reflect either reluctance to acknowledge a problem or the way dropout data are recorded. Students who transfer to a special program located off-campus and never return to regular school after delivery are rarely counted as dropouts. Young mothers who fail to return in the fall following delivery are often assumed to have transferred *somewhere* and are not recorded as dropouts. Loss is particularly likely during the move from junior to senior high.

Lack of trustworthy data about pregnancy-precipitated dropout rates obscures the dimensions of the problem, makes planning and programming difficult, and precludes special program outcome evaluations, since comparison figures are lacking. For similar reasons, it is obviously impossible to assess the effectiveness of programs designed to reduce the dropout rate, since neither the population of pregnancies nor the number of parents who leave school is known. As discussed in Chap. 2, there is a clear need to collect better data about dropout rates among teenage mothers.

In the absence of reliable pregnancy and dropout data, schools cannot determine the percentages of pregnant students choosing each of the available educational options (including termination). Nor can we estimate these percentages using our sample of pregnant students and teenage mothers, since we selected our respondents to represent, in roughly equal proportions, the major schooling options available. Nevertheless, data collected during discussions with pregnant students and teenage mothers about the decisions their pregnancies precipitated is valuable in assessing the effect of school policies and programs on these decision processes and how school is viewed from their perspective. The purpose of this chapter is to examine many of the issues discussed earlier, but this time from the perspective of pregnant and parenting teenagers themselves.

## SAMPLE

In field visits to 11 LEAs, Rand fieldwork staff interviewed a total of 121 young people. Of these, 57 were pregnant at the time of the interview and 62 were mothers.[1] We also interviewed two young fathers. Of these respondents, 68 percent are black, 29 percent white, and 3 percent Hispanic.

In locating a sample of potential interviewees we were heavily constrained by several factors. First, since our visits to each site were short, we were forced to depend on agency personnel on site to locate potential interviewees in advance of our visits.[2] They in turn were often constrained by their own or their agency's sense of propriety and by legitimate concerns for the privacy of their clients. These concerns led us to a sample limited to the publicly pregnant or the publicly parenting. School staff, for example, said they could not identify students who had chosen to abort a pregnancy, since that choice is rarely revealed to school staff. Efforts to interview nonpregnant, nonparenting students often met with resistance; we were told in several LEAs that the community would not tolerate their involvement in our study. It appears that students who show no public signs of sexual activity can expect more protectiveness from schools and other agencies than those who are visibly pregnant or parenting.[3] Although we hoped to interview both nonparents and students who had elected to terminate a pregnancy through abortion, our truncated sample, limited as it is to pregnant and parenting teenagers, is not inappropriate to the goals of the study, one of the most important of which is to understand how pregnant students and teenage mothers make school career decisions. Those who terminate a pregnancy do not drop out of school—at least not because of pregnancy. Similarly, the nonpregnant nonparent may leave, but parent status is not at issue here either. Thus our sample selects those most at risk of becoming pregnancy precipitated school dropouts.

Interviewees were solicited by school staff and the staff of other agencies with a teenage clientele. Potential interviewees were given a description of the project and their cooperation was solicited. If the student agreed to participate, an interview appointment was made. Teenage respondents were paid $5 for participating. A range of schooling options was represented in our sample. Among our respondents, 38 percent (N = 46) were enrolled in an inclusive curriculum program, 11 percent (N = 13) were attending supplementary curriculum or noncurricular programs, 31 percent (N = 38) were attending a regular school program only, 5 percent (N = 6) were involved in other educational programs (e.g., GED preparation, adult school), and 15 percent (N = 18) were dropouts.

The number of dropouts is disproportionately low, and these interviewees are probably not representative of all dropouts. The fact that they were solicited by social agencies, usually the schools, limited the dropout sample to those who had kept in touch and were probably coping more successfully. Indeed, several dropouts reported realistic plans to reenter school in the near future. Still, a dropout sample such as this remains useful for the study's purposes. Those who leave school but keep in touch may be the ones most likely to respond to policy changes designed to help them stay in school. This view is supported by the situation of several dropouts from an LEA in our sample where the child care component of the special program had been discontinued just that fall. Each had been in school the year before and had brought her baby to the center. Without the center, they were unable to find child care, so dropout was necessary.

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[1]Some of the pregnant interviewees had had previous pregnancies. However, since the interview focused on the current pregnancy, they were classified as pregnant in our count.

[2]Because we did not contact potential respondents, we do not have data on refusal rates.

[3]This may help to explain why male students usually escape the attention of school and other agency staff.

Respondents were generally willing to talk, to be frank, to admit mistakes and note triumphs.[4] A number thanked the interviewers for their interest and concern—a sign "of their great unmet needs for guidance," according to one Rand interviewer.

The sections that follow discuss students' views of pregnancy and parenthood, decisions they have made, and how they made them. The chapter ends with a brief discussion of the implications of these attitudes, decisions, and choices for school policies and programs.

Because this was not a study of teenage sexual activity and respondents were informed prior to consenting to an interview that sexual behavior would not be discussed, respondents were not asked about sexual activity or contraceptive practices. However, many respondents initiated discussions of such behavior in the course of the interview. These discussions are presented here because they illuminate an important aspect of teenage pregnancy and parenthood, namely, why it happens in the first place. The decisionmaking processes surrounding sexual activity and contraceptive practice also foreshadow subsequent decisions concerning pregnancy resolution.

## SEXUAL ACTIVITY AND CONTRACEPTIVE PRACTICE

Reports in the recent professional literature agree that more teenagers are sexually active, and at younger ages, than ever before (e.g., Zelnik and Kantner, 1977, 1978, 1980; Hopkins, 1977). Yet these data do not necessarily reflect a sexual revolution in which teenagers feel free to acknowledge their sexuality to themselves and others. In our sample, norms regarding sexual behavior were ambivalent. Many teenagers told us that sex is expected, that "everyone does it." Perhaps ironically, however, they often do not tell even their close friends that they engage in it. Indeed, many respondents told us that their friends reacted to the disclosure of their pregnancy with shock because they had been unaware of the respondents' sexual activity. Sometimes the shock was compounded because friends "didn't think she was the type."

Disclosure of sexual activity may be subject to differences in norms regarding appropriate behavior for young women and men. Our female interviewees told us that their boyfriends want sex, expect it, are expected by friends to have it, and often boast of it when they do. The girlfriend may want sexual activity as well, but it clearly is not a mark of social status or pride among young women and often is not revealed even to close friends.

Nearly all the respondents who chose to discuss contraception seemed fairly knowledgeable about at least some aspects of birth control; for example, a number noted concerns about the side-effects of the pill. Very few in our sample reported that they did not know about contraception or where and how contraceptive devices could be obtained.[5] Those who professed total ignorance were almost without exception very young (under 15). At ages 12, 13, and 14 it probably is difficult to learn about contraception or the family planning service delivery system since much of the information about these services is directed to older audiences. Additionally, the very young may be aware that society frowns on sexual activity at an early age, and therefore they often fail to ask anyone about how to receive contraceptive services.

Knowledge about contraception did not automatically lead to contraceptive practice in our sample. Use (and nonuse) of contraceptive procedures seems to reflect the ambivalence many

[4]A number of respondents welcomed an opportunity to provide information that might prevent others from making similar mistakes. Many of them remarked that teenage parenthood sounds considerably better than it is.

[5]However, their information is often incomplete. For example, one pregnant respondent told us that she and a friend had shared a prescription for birth control pills. "I took one one day and my girlfriend took one the next."

teenagers expressed about sex. Respondents gave many reasons for not using contraception. One set of reasons reflected cognitive immaturity and unstable self-perceptions, and thus may be characterized as distinctly "adolescent." For example, some said they failed to practice birth control because they thought they were too young to become pregnant, or because their sexual activity was sporadic. Many could not accept themselves as sexual, an obvious prerequisite to contraceptive practice. Said one interviewee in a typical comment, "Taking the pill means you are *planning* to have sex. I'm not that kind of person."

A number of respondents had used birth control methods at some point, but became pregnant when they stopped. They mentioned running out of pills and never returning for more, or becoming afraid of the side-effects of pills but failing to obtain an alternative method.[6] Several had pills but simply forgot to take them. One interviewer summed up the problem of contraceptive use among teenagers with a waiting room vignette she witnessed when she arrived early for an appointment with the director of a clinic oriented to a teenage clientele.

> A girl about 15 was telling the (clinic) nurse that she still had symptoms of a bladder infection, which the nurse had obviously treated some days earlier. The nurse asked if she'd been taking the pills that had been prescribed. The girl said yes. The nurse said, "How many pills did you take yesterday?" The girl grinned and said "one." The nurse pointed out that four daily had been prescribed, and that she couldn't hope to rid herself of the infection and its painful symptoms if she didn't take all four pills each day. If compliance in the presence of immediate and painful symptoms is this hard for a 15-year-old, obtaining compliance for a drug to protect against pregnancy should intercourse occur seems a monumental, maybe impossible task.

A very small proportion of our sample admitted that their failure to use birth control was, as one commented, "part-way planned." A major motivation for such "part-way" planning is often concern about keeping a boyfriend. Said one respondent who became a mother at 13, "A lot of girls think that getting pregnant will keep their boyfriend, and a lot of guys are saying, 'If you love me, you will have my baby.'"

Other factors, possibly reflecting socioemotional difficulties in the teenager or in her family, may also motivate pregnancy. Several respondents mentioned that they wanted a baby as a companion. Said one, "I wanted someone to love who I could take care of and who would love me."[7] Another told us that she was jealous of the attention her 16-year-old sister received when she had borne a baby the year before. More than one respondent told us the current pregnancy followed an abortion forced by parents, a miscarriage, or a stillbirth.

## PREGNANCY

### Confirmation of Pregnancy

In most cases, respondents suspected pregnancy early, but delayed a pregnancy test until several periods had been missed. The reason for delay in most cases seemed to be denial. Said

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[6]One director of an in-school clinic noted that medical practitioners have done teenagers a disservice by presenting the pill as the only "effective" contraceptive. While its clinical efficacy is higher than other methods, it is not well suited to the often sporadic sexual behavior of teenagers and the discomfort many feel with "premeditated" sex. Many teenagers believe there is no worthwhile alternative to the pill and therefore may not use any contraceptive if the pill is unavailable or unacceptable for any reason.

[7]A Planned Parenthood counselor, acknowledging this motivation to give and receive care and affection suggested (and said she was "not kidding") that it can sometimes be fulfilled by a cat, dog, rabbit, or other pet.

one young mother in a typical comment, "I suspected it but I didn't want to find out through a pregnancy test." In this case, a clinic visit was made in the fourth month of pregnancy. Respondents were generally directed to the clinic where pregnancy tests were available by a friend or relative who was or had been pregnant. A few respondents heard about the clinic on the radio; fewer still learned of it from parents or school staff members.

Because of denial, the positive pregnancy test marks the first time that many students consider pregnancy-related decisions. Clinic staff generally discuss options with pregnant clients. Pregnancy decisionmaking is later discussed with parents, and sometimes the boyfriend. But before this occurs, the reality of a pregnancy must be faced.

**Reactions to Pregnancy**

In spite of lack of consistent contraceptive practice in nearly every case, many interviewees reported shock when their pregnancy was confirmed. Most, even those who wanted to be pregnant, also experienced fear; most feared were parental reactions. A few were so afraid to tell their parents that they put off the revelation for as long as six months. In more than one family, this withholding of information meant that an abortion, although favored by the respondent and her parents, was not possible. In a few cases, respondents intentionally withheld revelation of a pregnancy so that anticipated parental demand for an abortion could not possibly be met.

In almost every case, the parental reaction was far more benign and supportive than had been expected; parents were typically described as disappointed but resigned. Mothers generally were more supportive and less angry than fathers. In some cases, resignation grew out of the parents' own attitudes toward pregnancy and abortion. Said one interviewee, a Catholic, "My parents were extremely angry at first, but since they didn't approve of abortion, they kind of decided they had to be supportive." Only a few of those we interviewed were forced to leave their homes because of pregnancy—in one case because the baby would be of mixed racial background. Only one respondent described her mother as "happy" about the pregnancy. She described herself as shy and withdrawn, and the pregnancy was welcome evidence to her mother that she was having a sexual relationship.

When parental rage did not materialize, some of the interviewees were able to experience pleasure and excitement about the pregnancy. Many began to establish justifications for the pregnancy that reinforced their good feelings about it. For example, one interviewee commented that "I always wanted a lot of kids, so getting an early start is a good idea." Several noted that they were lucky to be pregnant, since some people never can conceive. Many reported that young motherhood has real advantages in terms of closeness in age to one's children. Said one 15-year-old of her unborn child, "I'll be able to understand him better because we'll be in the same generation."

Many interviewees reported feeling embarrassed about the pregnancy at first. Some said they felt stupid for being "caught." In most cases, these negative feelings coexisted with positive ones. By the time we interviewed them, when all were in at least the second trimester of pregnancy, delivery was eagerly awaited by most. Some respondents continued to feel embarrassed and upset; most of these respondents lived in a community where teenage pregnancy was seen as a moral transgression and abortion was not condoned.

A major factor in the generally positive attitudes of most interviewees was the strong support and acceptance they received from close friends. Most said that close (female) friends were "sticking by" them; some reported that their friends were begging to be godmothers. A

number had been given showers by friends. In some sites, respondents differentiated the attitudes of "friends" from those of "the other kids." Friends were supportive, the others were not. If friends were not supportive, they were no longer considered friends.

The attitudes of male peers seemed to be more varied. In some sites, interviewees described boys as indifferent or uninterested. In others, boys were described as jealous. Said one respondent, "The other guys were jealous that ——— is the father. They wanted to be the father (of the baby)." A few individuals said that a pregnancy made them more popular, since they were assumed to be available for sex.

School staff corroborated these perceptions of peer support. Most found that pregnant students, especially at the high school level, were well accepted by peers. There was, however, variation in acceptance by group and community. Said one principal in a large urban LEA, "(Pregnant) students are quite well accepted and have no difficulty maintaining their friends. . . . There may be some hidden stigmatizing . . . people gossiping about a girl behind her back. And maybe very serious young men would not think of her as a good marriage prospect."

In very conservative communities, acceptance by friends was sometimes vetoed by their parents. One respondent told us her daughter had been involved in planning a shower for a pregnant friend; the plans were dropped when her daughter learned several students would not be permitted to attend.

Pregnancy at the junior high level is a different story. Junior high school students we interviewed told us many students were hostile, and good friends often deserted. One who had become pregnant at 13 said she was often called a "whore" and was involved in many fights. "Being pregnant in high school is easier," she said.

Fathers-to-be had a range of reactions to pregnancy, according to our female respondents. Some were pleased and excited, a few denied paternity and deserted, many were frightened and surprised. In a number of cases, the father-to-be wanted an abortion; in our sample of teenage parents this opinion was ignored. In most cases this led to the breakup of the relationship, though in a few cases the father-to-be came to think parenthood was a good idea and lent his support.

The two fathers with whom we spoke said their impending paternity was treated by friends with great respect; one young man said he was often called a "stud." However, he said that deep down he felt the other guys "thought he was dumb to become a father, and even dumber" to take responsibility for the baby and marry the mother. However, his close friends as well as his parents supported his decision to marry.

Pregnant students generally found school staff to be neutral about pregnancy, but some then described negative views. Said one student, "They (school staff) are helpful and understanding but they think their parents (of pregnant teenagers) didn't raise them right." Many assessed school staff attitudes fairly accurately. Said one, "They think we're too young to have babies, but it's basically our decision." Said another, "Teachers and counselors think it's better to wait, but they say, 'Well, it has happened so we will have to help her make the best decisions that she can.'" In some sites students rarely informed regular school staff of their pregnancies, so they had little direct experience to report. Most, however, believed school staff would react in a neutral or negative way. For some, withholding of pregnancy information from school staff was due more to embarrassment than to expected disapproval. Said one pregnant student, "I didn't tell any of the teachers because they would have told other teachers, and then everyone would know."

## Pregnancy Decisionmaking

Faced with an unplanned and usually unwanted pregnancy, a decision must be made—by someone—about how to resolve it. Four options are in fact available: abortion; carrying to term and relinquishing for adoption; carrying to term and keeping the baby as a single mother; or marrying the father (or another young man) and assuming the roles of both wife and mother. The pregnancy resolution decision is an important one that has long-term implications for a student's career, social status, and well-being. As such, it should be made with care. A "rational" decision would ideally involve exploration of all the resolution options and an assessment of each in terms of its implications for current and future goals and outcomes for mother, prospective child, and other family members. How close do the decisions respondents actually make come to the "rational" model? Their decisionmaking processes are described below.

In our sample of 119 young women, no more than 3 could be said to have given open consideration to all four pregnancy resolution options. In some cases, one option, abortion, was immediately rejected on moral or religious grounds. Other options were ignored or rejected on grounds that were in some cases reasoned, in some cases irrational.

As evidenced in recent data on pregnancy resolution decisions among teenagers (e.g., Zelnik and Kantner, 1978), adoption has become an extremely unpopular way to resolve an unplanned pregnancy. A number of research studies have dropped adoption as a potential resolution category because so few women now give up their infants for adoption.[8] In our sample of pregnant and parenting teenagers, only a few had seriously considered adoption. Two sets of reasons were given for early and firm rejection of this alternative. The first, and perhaps more psychologically compelling reason, is that a number of our respondents were themselves the daughters of teenage mothers, who were also typically unwed at the time of their birth. Since their mothers had kept and raised them, they felt they owed at least this much to their unborn child. One young mother who had decided to keep her baby was raised by her single mother. She said "My mother didn't get rid of me, so I couldn't get rid of my baby."

Most respondents who discussed adoption viewed it as a punishment for the baby. One mother said in a typical comment, "It's not the baby's fault. He shouldn't be separated from his real mother." Some noted the psychological toll adoption would take on them. Said one pregnant respondent who planned to raise her child alone, "I didn't want to be one of those (mothers) who didn't know where their baby is." No respondent mentioned any of the potentially "positive" aspects of adoption for the child that were often advanced a generation ago, such as "wantedness," having an intact family, and a more secure future.

Reinforcing pregnant teenagers' negative views of adoption were strong peer norms against it. Indeed, this seemed an issue about which peers, generally presented as tolerant of most life styles and personal decisions, were extremely intolerant. Said one young mother who chose to raise her baby herself, "The kids would have hated me if I had given up the baby. Even my good friends could...take that." This respondent noted that one student in her high school had relinquished her baby for adoption, and had been socially ostracized. "Nobody would speak to her, though it was probably the right decision for her to make." Special program heads are sensitive to the strong antiadoption attitudes among pregnant teenagers and their peers.[9] One program head urges enrollees considering adoption not to tell any of the other enrollees.

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[8]Many believe that a small but significant number of women decide to relinquish a baby for adoption at some later point. However, this decision is obviously separated in time from the pregnancy resolution decision.

[9]While in the past the staff of isolated programs were successful in creating strong norms which supported relinquishment (Sedlak, 1980), peer pressures in these programs today make it hard for enrollees contemplating adoption to carry it out.

Another program head suggests that a teenage mother who relinquishes her baby should consider transfer to a different high school when she leaves the inclusive curriculum program.

Abortion was only a slightly more acceptable option to our sample.[10] Many of the interviewees viewed it as murder. In one interview, a black respondent noted that she had been "disgusted" to see "a black lady on television from some clinic talking about killing babies." Peers and parents often support such negative attitudes toward abortion. In a substantial minority of families, however, respondents and their parents did not agree about abortion as a pregnancy resolution option. In our sample, such disagreements pitted parents strongly urging abortion against a daughter's desire to carry and keep the child. Respondents reported that parents generally recommended abortion out of concern for the implications of early parenthood. These parents worried that a baby would make it impossible for their daughter to finish high school or attend college. Daughters themselves regarded such concerns as either unfounded or irrelevant. In our limited sample of deliverers, the daughter prevailed in each of these cases, even though in one instance the daughter left the family home as a result. In a few cases the disagreement had not yet been resolved. In one site several respondents asked Rand staff interviewers about their legal rights in such disagreements, requests which showed both the intensity of pregnant teenagers' feelings and their ignorance concerning these important matters.

Interviewees' generally negative views of abortion were reinforced by their lack of positive reasons to have one. As noted above, school or career factors were generally felt to be irrelevant to the decision. A number shared the views of one 16-year-old mother: "I wanted one (baby) sometime, so why not have *this* baby?" As mentioned earlier, several thought by having a baby as a teenager, they could avoid generational conflicts they were currently experiencing in their own lives. Some cited the parenting experiences of sisters and friends as a sign that they too could cope well with motherhood.

Marriage was an option rarely chosen by our interviewees, but one that received the closest scrutiny and most careful consideration. Many respondents had received marriage proposals, typically precipitated by the pregnancy. These proposals were usually rejected because of the belief that marriage would simply exacerbate an already difficult situation. A number of respondents pointed to the immaturity of the prospective husband and his lack of earning power as problems. Several noted that they were "too young to make such an important decision." A substantial number did not want to marry for what they saw as the "wrong" reasons. One 18-year-old had discussed marriage with her boyfriend but decided against it, because she didn't want "to be tied down to someone who doesn't love me but only wanted me because of the baby." Most, however, said that the institution of marriage itself would create problems by isolating them from a supportive family environment. Once married, there would be only an immature husband to depend on; consequently, the young wife would have to assume major household and parenting responsibilities. In contrast, if she stayed in her family of origin she could receive continuing "live in" child care help from her own mother and often from her siblings as well.[11] One 16-year-old, for example, had refused to marry her boyfriend because "people see you as older and more responsible when you're married."

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[10]It is important to keep in mind that our sample of teenagers was biased: Pregnant teenagers who found abortion acceptable and aborted a pregnancy were not interviewed.

[11]The research literature suggests that decisions not to marry are indeed advantageous to both mothers and babies. While teenage mothers increase their likelihood of dropping out of school, married mothers are twice as likely as unmarried mothers to do so (Moore et al., 1979). Those mothers who do not marry and who live with parents or relatives are generally better off than those living alone or with a husband. More return to school, graduate, and are employed (Furstenberg and Crawford, 1978). Babies benefit from having more than one caretaker, especially when the additional caretaker is their more experienced grandmother (Baldwin and Cain, 1980).

Interviewees' feelings against marriage were generally decisive because in most cases parents agreed. So did peers. While many interviewees said they thought school staff were neutral about marriage, one said teachers thought "you were even dumber if you got married." School personnel regarded marriage as generally not a good idea and did not encourage it, even in conservative communities.

One LEA in our sample was unique in its high rate of marriage. In this conservative district abortion was generally unacceptable. The middle-class respondents we interviewed reported that their parents strongly believed marriage to be a positive and necessary step and would exert pressure on the prospective father and his family even when he—and their daughter—were reluctant.

Given the considerations just described, carrying and keeping the baby and remaining single were generally seen as the best or, for some, the least objectionable option available. Most interviewees gave little or no thought to the costs inherent in this option, but simply saw it as the only option left. Few had considered who would care for the child, how much money would be needed for its support, or where the money would come from. Said one pregnant respondent in a typical reply, "I haven't worked all that out yet, but I'll manage somehow."

Few students appeared to consider educational plans in deciding how to resolve a pregnancy. Most viewed schooling concerns as irrelevant to pregnancy resolution decisions and felt the latter decision had to be made before the former concerns could be considered. Nor were school programs a significant factor in pregnancy resolution decisions.[12]

The pregnancy resolution decision in almost every case was made without regular school staff involvement. Respondents were often incredulous when questioned about a school staff role in this decision. Said one, "Why would I talk to my counselor about it? I have never talked to her about anything personal before." Said another, "It never entered my mind (to talk to a teacher or counselor)." Most pregnant students regarded the decision as theirs to make, in conjunction with family members and perhaps the prospective father; it was not the school's business. Many did not believe the school would be helpful in any way; some thought staff would be disapproving; a number believed their confidentiality would not be respected. Consequently, pregnant students tended to contact school staff very late in the decision process and then only to get objective answers about schooling options. Their unwillingness to involve school staff in pregnancy resolution decisions met no active resistance. As discussed in Chap. 4, counselors and other regular school staff are generally reluctant to become involved in pregnancy resolution decisions, which they view as personal or family matters. Involvement is generally avoided by taking a passive stance about pregnancy: If the school waits to be told of a pregnancy, the pregnancy resolution decision will almost always have been made by that point.

Lack of school involvement in pregnancy resolution decisions provides no counter to students' beliefs that school and career concerns are secondary to the more important pregnancy resolution decision, or else that parenthood will have no effect on school or career plans. While school staff reluctance to become involved in these decisions is understandable, their lack of involvement often means that no one points out the interrelatedness of pregnancy, school, and career decisions and the need to make them jointly rather than serially.

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[12]Many students did know of the inclusive curriculum or other special program, having heard about it from friends or sisters. In some cases, this led to even less motivation to contact school staff. Said one student, "I just knew I'd go there (inclusive curriculum program). I didn't need to talk to anyone at school."

## SCHOOL CAREER DECISIONMAKING

### Predelivery Decisions

Once a pregnancy resolution decision has been made, educational and other decisions are tackled. Each pregnant student must make two decisions about her school career early in her pregnancy. First, she must decide whether to continue in school or drop out. Second, if she decides to continue, she must decide on a specific educational alternative. Initial dropout and program decisions may be interrelated. Indeed, special programs have often been established in the hope that their existence will influence pregnant students to remain in school. In our sample, however, this was often not the case. How these students made school career decisions is discussed below.

**The Dropout Decision.** In our sample, the decision to drop out or continue with school was almost always made prior to informing the school of the pregnancy. Only after making this decision did those who chose to remain in school—or their parents—contact school staff to inquire about available educational options. Most students who decided to leave school never contacted school staff. For example, one 16-year-old attended school through the academic year, delivered her baby early the next fall, and simply did not return to school. She did not contact anyone about her decision, and no one from the school contacted her. A few dropouts did inform school staff of their intention to withdraw. One 16-year-old talked to the dean about her decision to withdraw. The dean gave her a slip which was signed by her teachers. She said, "It was easy. No questions were asked."[13]

Many students seemed to have difficulty explaining *why* they chose to continue in school, which may simply indicate that the dropping-out option was never seriously considered. Most respondents (dropouts as well as those in school) reported that in their view pregnancy or motherhood was not a good reason for termination. Several noted that parenthood brought an increased obligation to finish school. Said one student, "I owe it to my baby to finish school. I have to support him and set a good example." Most simply said dropping out was stupid or cowardly. In general, pregnant students who left school were regarded as lazy, although a few respondents noted that embarrassment may cause some students to drop out.[14]

Four of the 17 dropouts we interviewed had left school prior to pregnancy because they found it boring or too hard. Two others had had chronic attendance problems which became so severe during pregnancy that they were failing all subjects and left. Four of the interviewed dropouts had more than one child. Difficulties in making multiple child care arrangements led to leaving regular school. However, all four of these regular school dropouts were in an education program at the time we interviewed them; two were pursuing GEDs, one was in an adult education program, and one was taking correspondence courses. Still another dropout had left her junior high school when pregnancy was confirmed, but planned to return to school after delivery. In her LEA, temporary school dropout among pregnant white students was not uncommon and was sometimes suggested by school staff.

The remaining dropouts could not clearly articulate why they had left school during

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[13]This LEA is located in a state where pregnant and parent teenagers are exempted from school regardless of age. Such a policy may have contributed to the ease of withdrawal from school in this case. (See Chap. 1 for a discussion of the effects of these policies on school response to student pregnancy and parenthood.)

[14]Respondents also believed some pregnant students leave school because they do not like school; pregnancy is an acceptable excuse in these cases. A few were thought to have left because they could not afford decent maternity clothes.

pregnancy or after delivery. However, each seemed to feel that having a baby and taking care of it was more important than going to high school.

School staff generally agreed that educational continuation depends heavily on peer and family pressures not to leave. Dropouts were described by one school counselor as "girls who lack support for staying in school. Family and friends often feel strongly that school isn't important or that pregnant girls and mothers don't belong there." Said one special program head, "There are multiple problems: transportation, family pressure to stay home, lack of child care, boyfriends who don't want the girls in school."

The relationship between the availability of special programs and dropout decisions is not entirely clear. For most of our dropout sample, the termination decision was made without any knowledge or consideration of educational program options. However, the decision of stayers to continue might have been adversely affected *later on* had a special program not been available. In the most conservative districts we visited, inclusive curriculum program availability definitely helped prevent school dropout during pregnancy. In these LEAs, students typically withdrew from regular classes immediately upon confirmation of a pregnancy even when they were counseled to remain in regular school until the end of the marking period or semester. Had there been no inclusive curriculum program in these districts, in all likelihood pregnant students would have left, though perhaps only temporarily. Indeed, in two conservative LEAs, parents of pregnant teenagers sometimes forbade even inclusive curriculum program attendance. In these instances, the district acquiesced, supplying homebound instruction in one case and nothing in the other.

**Program Decisions.** Once the student has decided to stay in school, she must decide where to attend. Some pregnant students make this decision on their own. Many do not. As discussed in Chap. 4, regular school staff often intervene in this decision, frequently giving special emphasis to a favored option, and sometimes not mentioning a nonpreferred option. In some cases school staff are not themselves fully informed of available options, particularly when an option is not school-related. For example, one community boasts a GED program that pays mothers to attend and provides child care. Few school staff know about it, however, despite the fact that lack of child care precludes regular school continuation for some mothers.

In LEAs with an inclusive curriculum program, this program is the major alternative to remaining in regular school. Where a noninclusive program is available, pregnant students may choose to enroll in it or not while attending regular school. In some LEAs other options are available as well, such as adult school or community-based programs.

Which alternative a pregnant student chooses depends in part on the information available to her. Our interviews indicated that the range of possible educational options is usually greater than the range of options actually considered by pregnant students.

In one site, where no pregnant students remained in regular school, most interviewees were not aware they could in fact have stayed; they perceived their options as dropping out or attending the inclusive curriculum program. In two other sites, students said they chose to attend the inclusive curriculum program in preference to remaining in regular school because of a general attitude that this is "what you did" in those sites when you became pregnant.

In an LEA with a large inclusive curriculum program, many interviewees were not aware of all their educational options. In some cases school personnel had discussed schooling options with them, while others learned of the inclusive curriculum program from friends who had attended. Some said they deduced they could remain in their regular school only because they had seen pregnant students on campus. In several cases, students received erroneous information from school staff. For example, one respondent transferred to the inclusive curriculum program to ensure she would get home-tutoring after delivery. In discussing her options with the school social worker, she understood she could receive such tutoring only if she did so.

Subsequent interviews revealed that several regular school respondents in this LEA believed (erroneously) that homebound instruction was available only to those enrolled in the inclusive curriculum program.

One reason students may not be fully informed about education options is that neither they nor their parents aggressively pursue this information. It was evident from our interviews that pregnant students and their families generally do not approach the question of school continuation as if the student has any educational rights. Rather, they approach as transgressors, asking, "Is there anything you can do to help our daughter?" Given this attitude, any alternative the school suggests is seized upon gratefully and without question.

Although not always based on full information, program decisions seemed well reasoned. Perhaps because they are less emotional than pregnancy resolution decisions, students are able to weigh carefully the educational options they are aware of.

Students who chose an inclusive curriculum program (in preference to regular school attendance) generally mentioned program features as the major factor in their transfer decision. These programs were particularly appealing because of their "relevant learning" components, especially child development and parenting courses. These students also believed program staff would be more understanding of their needs, and that they would get more counseling and individual attention than they could expect in regular school. A number mentioned that program staff would be more tolerant of time missed for clinic appointments and delivery, and the (often shortened) schedule would allow time to make up missed work.

For a few students, negative aspects of the regular school setting complemented initial positive reactions to the off-campus setting. Interviewees cited the anger of the father-to-be (in cases where he wanted an abortion), the jealousy of the father-to-be's former girlfriends, and "gossip" as factors that contributed to their decision to transfer. Very few mentioned negative staff attitudes as a factor in the school environment that contributed to a transfer decision. Nor were negative peer attitudes viewed as important except in the most conservative districts and among junior high school students. A number of interviewees mentioned physical aspects of the regular school setting as drawbacks, especially stairs, crowded hallways, and shoving students. However, negative aspects of regular school settings were rarely a deciding factor in transfer decisions. Those who chose to stay in regular school mentioned many of the same drawbacks but stayed in spite of them. For example, one student chose to remain in regular classes even though the former girlfriend of the father-to-be was spreading rumors that she had gotten pregnant to keep him. Another who became pregnant in junior high stayed despite widespread talk that she was a "whore." She engaged in several fights with female peers over this name-calling, but was determined not to be driven from school.[15]

Pregnant students who rejected an inclusive curriculum program in favor of regular school attendance generally did so for two reasons. First were academic considerations: A number of the inclusive curriculum programs we visited were viewed by both students and staff as academically weak. Students who chose to remain in regular school during pregnancy noted that they could continue advanced or specialized coursework, learn more, or "keep up" by remaining in regular school. In a few cases, students told us that their counselor had advised remaining in regular school for this reason. While several regretted losing the opportunity to take child development and other "relevant" coursework by staying in regular school, academic concerns were felt to outweigh these advantages. Peer considerations were also frequently

[15]In this LEA, the special program for pregnant students is located in a continuation school with a reputation so bad that few school staff or students considered it a real option for those who were "only" pregnant.

important in a decision to remain in regular school. Many of the students who chose to stay in regular classes said they did not want to be isolated from their friends.

A few students selected regular school over an inclusive curriculum program because of negative aspects of the program. Mentioned in this regard were transportation problems and social relations among enrollees. In more than one site, students both in and out of inclusive curriculum programs told us of competitiveness for males and criticism of those considered too young or promiscuous.[16] One dropout said she rejected the alternative site program because she "didn't want to be around a bunch of catty girls."

In the LEA we visited that had both an inclusive curriculum and noncurricular program, the existence of the on-campus noncurricular program seemed to play only a minor role in interviewees' decisions to stay in regular school. Those who chose to remain in regular school did so largely on the basis of school features such as the availability of college prep courses or job training programs, or the fact that regular school offered interaction with friends. The noncurricular program was regarded by these students as a bonus that reinforced their decision. Said one student who discussed schooling options with the head of the noncurricular program, "I decided I didn't want to leave school, although Mrs. —— (noncurricular program director) did mention the (inclusive curriculum) program. I liked my friends and my classes so I decided to stay." This same student said she had never discussed her pregnancy with regular school staff. "I really didn't need to. The (noncurricular program) has given me everything I wanted to know." Another student in this district said that although the school nurse wanted her to go to the inclusive curriculum program, she decided to stay when she found out from noncurricular program staff that she did not have to. "I didn't want to be taken from my friends. It's hard enough coping with pregnancy. Being taken from your friends makes it worse."[17]

### Postdelivery Decisions

Because schooling is at least briefly interrupted by childbirth, a decision to continue must be made again after delivery. For students attending regular school, the decision simply involves resumption of the curriculum established during pregnancy. For those who transferred to an inclusive curriculum program, a decision must be made to transfer back to regular school. These decisions are far from automatic. Indeed, many school staff noted that the postdelivery decision time is a common dropout point. The protective and supportive environment provided by the inclusive curriculum program during pregnancy is withdrawn, often abruptly, soon after delivery. At the same time, child care, night feedings, and fatigue have become new realities. Further, students who transferred to the inclusive curriculum program out of embarrassment must now return to face the peers they sought to avoid.

Several students in our sample made the transition successfully. Each attributed her success to substantial support from parents, including provision of child care at home, taking turns at night feedings, and encouragement to return to regular school. Those who dropped out after delivery generally did so because they were unable to make satisfactory child care arrangements, or could only do so at substantial personal cost. For example, one young mother did not return to school when postdelivery homebound instruction ended. "The bus came at

[16]In one program, one young man had fathered three babies. The three future mothers—all enrolled in the program—vied for the status of "most loved."

[17]While an on-campus special program may not be seen as a reason for choosing regular school when an initial schooling decision is made, a number of noninclusive program enrollees noted that the program had been enormously helpful later on, particularly when the going got a little rough.

7:15, and I had to (turn over my baby) to the child care lady before I could get on it. I just couldn't handle it." This experience was not unique. The director of an on-campus child care center in another district told us that enrollment in the center (and of mothers in school) had declined sharply when the school went on split sessions, with classes beginning at 7:15. While discouraged at the poor attendance, she could understand the problems: "Girls must be up extremely early with their babies in order to get them to the center and into school. Many of them have been up several times during the night." In a few schools, attempts were made to minimize these problems by scheduling a free first period. But as discussed in Chap. 4, the regular school did little to promote students' postdelivery reenrollment and retention. In many cases the school was not even aware a student was supposed to be returning until she arrived. If she did not appear, she was usually not missed.[18]

Two of the dropouts in our sample made the transfer back into regular school after delivery, but their attendance became increasingly poor until they were failing all their classes. School staff viewed these teenage mothers as destined to leave. Their poor attendance after delivery was, said one counselor, "just a continuation of their prepregnancy attendance habits." Given these views, school staff did not intervene in any positive way to support or facilitate school continuation.

Schools with a supplementary curriculum or noncurricular program are able to provide student mothers a range of specialized services designed to promote their reenrollment and retention. However, not all students who were attending schools with in-school programs used program services. One reason for nonuse of postnatal programs was that participation was sometimes contingent on bringing the baby to the program's child care center. Those who had a family member willing to provide child care at home generally did not enroll, since a family member was a preferred child care provider. As a result, the participation rate among eligible mothers was low. When enrollment was not contingent on child care arrangements, use of on-campus programs was higher. Mothers who used these programs enrolled because, as one respondent said, "The services are free, confidential, close by, and I need them."

Those who brought their babies to on-campus child care centers were pleased with the arrangement. Said one respondent, "He (the baby) is close to me in case there is a problem but I'm still in school. Its better than leaving him at home because if there's a problem I can get help much easier here."

### Program Evaluations

In general, students liked the programs in which they were enrolled. Strong regrets were heard only from those who realized they had made an uninformed choice. For example, one student learned of the inclusive curriculum program only after having arranged for homebound instruction and did not feel free to change the plan. She felt very isolated, although she attended some components of the inclusive curriculum program.

Students who attended inclusive curriculum programs were everywhere very enthusiastic about program staff, describing them as nice, understanding, and helpful. Said one respondent, "The people here care more than teachers I am used to." Inclusive curriculum program enrollees often underscored the nonjudgmental, individualized environment. Said one enrollee, "I like the people and the atmosphere. Here I'm not treated as if I had done something wrong."

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[18]Because of transfer policies, such students are usually not counted as dropouts. By not including such "failures to reenroll" in dropout counts, reports of dropout rates among pregnant students and teenage mothers may be spuriously low.

Said another, "I seem to get more accomplished without the pressure of a big classroom." Most of the students acknowledged that the coursework was easy. For many this was a plus. Said one, "At this time in my life I need to concentrate on what's happening to me." A few, however, missed the academic rigor and advanced coursework, and had made plans to take missed courses upon return to regular school. Others regretted the lack of physical education classes or extracurricular activities.

Students enrolled in noninclusive programs were also enthusiastic, particularly in districts where the program provided essential services such as child care or health care. They particularly appreciated program staff concern and understanding, and the fact that they could learn about their babies while attending regular classes. Several respondents applauded the "support groups" that the programs provide. Said one teenage father of the supplementary curriculum program in which he is enrolled, "It's what's keeping us (him and his wife) coming to school and not dropping out. The teachers (in the program) encourage us, take care of the kids, and teach us about contraceptives."

## THE IMPACT OF PARENTHOOD

More than half of the teenagers to whom we spoke were parents. We asked them about their view of parenthood and its impact on their lives.

The majority of mothers told us that if they could do it all again, and knew what they knew now, they would not have become teenage parents. Some said they would have avoided pregnancy by use of effective contraceptives; others, assuming they were already pregnant, said they would abort. Said an interviewer of one site she visited, "I asked several respondents if they had it to do all over again would they get pregnant. Without hesitation, every one answered with a resounding 'No!'" A number of mothers expressed a wish somehow to share their newfound wisdom with those teenagers who are not pregnant or who are pregnant and considering their options. One mother who said she would definitely abort if she had it to do over said, "I wish I could talk to pregnant girls and tell them what it is really like to have a child." Said a 15-year-old mother, "Most of my friends think that it's really great that I've managed to have a baby, keep him, and continue in school. I constantly remind them that while it looks like there are no problems it's really hard and they should use contraception."[19]

Teenage parents cited a number of reasons for delaying parenthood until school completion, including fatigue, constricted social life, and loss of adolescence. Said one mother, "I was a baby myself until I had my baby." Said another who had her baby at age 13, "It would have been nice to be a teenager but now I have —— (baby) and really love him." Several interviewees believed that it would have been better to wait until high school graduation to become a mother because then they could have stayed home with their child. For example, one eleventh-grade mother of a two-year-old commented, "I would have loved to stay at home with —— if I was through school, but I wasn't. School was something that had to get done."

While high school parenthood was not recommended, the student mothers expressed great love for their babies and general satisfaction with their lives. A number cited positive aspects of early parenthood, including a more serious attitude toward life and more motivation to do well in school. Several interviewees reported that their grades had improved since their child

[19]Such remarks tend to support the view of some school staff that retaining parents in regular school helps provide other students with a more realistic view of the constraints of early parenting. (See Chap. 4 for further discussion of staff views concerning mainstreaming of parenting students.)

was born; school staff corroborated the view that student mothers seemed more mature than those who were pregnant. One counselor suggested that the greater maturity of the parents "could indicate that delivery and the responsibility for the care of their infant had proved to be a sobering experience."

The impact of pregnancy and parenthood on the respondents' lives varied considerably. For some it was slight, the inconveniences few, and the benefits large. For others, pregnancy and parenthood had resulted in enormous changes and a life style far different from their teenage pursuits before childbearing.

Interviewees for whom pregnancy and parenthood constituted, at worst, a minimal interruption in their lives were generally those who lived at home; their own mothers took over much, if not all, of the responsibility for the baby. For example, one junior high school student had her baby during the summer between 8th and 9th grades, and she missed no school. Her mother took on full responsibility for the baby. Except for having to wash dishes more often, she said her life had not changed at all. She still goes out with friends and gets to have a good time. Other students told us that parenthood brought new privileges without any new responsibilities. One 14-year-old told us that before her pregnancy she had to keep house for the family and was not allowed to go anywhere. Since her baby's birth her mother has lightened her household responsibilities and repealed her curfew time, saying that it seemed foolish to require a *mother* to be home at a certain time. Now she can go anywhere as long as she gets a babysitter.[20] Several respondents told us that their relations with their mothers had improved markedly since their baby was born.

A few teenage parents reported that pregnancy and parenthood had completely changed their lives, mostly for the worse. One young mother described her life as "terrible." Her parents wanted her to abort, and her refusal to do so precipitated her moving out. She is totally on her own, going to school during the day and working nights to support her frequently ill child. Only her goal—to be the first in her family to graduate from high school—keeps her from dropping out.

Most teenage parents to whom we spoke fell somewhere between the two extremes; for them the experience of pregnancy and parenthood has had both positive and negative aspects. The young mothers love their babies very much, but parenting at their age is difficult. It is not easy to do school work and take care of a child. Often social activities must be curtailed. Frequently, the babies' fathers do not provide the emotional and material support the mothers expected.

As discussed above, most respondents reported that their friends had rallied around them during pregnancy. Parenthood, however, brought significant changes in friendship patterns for many. Those who were the first or only mothers in their peer group were most likely to report having fewer or different friends. The responsibilities of child care and scarce leisure time had narrowed their social circle. Said one young mother, "I simply don't have time for other people besides my boyfriend and my baby." For others, friendship patterns had changed. A number of respondents had met and become good friends with other mothers in a special program. Many reported feeling closer to pregnant and parenting friends now, and less close to other friends.

Several adult respondents acknowledged that social relations during pregnancy and the initial parenthood period are generally satisfactory, with little of the social stigma and isolation formerly accompanying teenage motherhood. However, they viewed the longer-term picture as more distressing. The following scenario was thought not to be uncommon. In the first months

[20]Our respondents' reports are consistent with a number of anthropological studies of low-income urban blacks, which found that single adolescents tend to gain a more adult status following delivery. The new status is characterized by diminished parental control (Ladner, 1972; Stack, 1974).

after delivery, the new mother's friendship group is very supportive, protective, and interested in her new situation. They bring presents and visit often. But the novelty wears off, and the fact that the new mother is sharing fewer social experiences with her friends results in fewer visits and progressively greater isolation. The novelty of parenthood may begin to wear off for the mother as well. The presence of supportive family members who can and will supply child care makes a tremendous difference.

Few of the teenagers we interviewed had been parents very long—the oldest babies were about two years old. They did not report severe social isolation, though several noted that parenting increasingly interfered with social activities as the child became a toddler.[21] In most cases school was proving to be a positive influence in the lives of those who stayed; whether they attended regular school or a special program, or both, they were in the company of people their own age, including at least a few other mothers, for several hours each day. Students in inclusive curriculum programs made friends with other parenting teenagers; those in regular school were with their own friends. These social relationships provided some peer interaction and support, and a chance to get away from the responsibilities of parenthood.

For most interviewees, parenthood seemed to have had only a small impact on career or other future plans. Among the youngest respondents, absence of impact on expectations reflected lack of well-defined plans for the future, not surprising in 13-to-15-year-olds. Many older respondents, whose goals were better articulated, saw pregnancy and parenthood as having no major effects, although several anticipated that it might take longer to reach a desired goal. Their job goals, often involving clerical or other traditional female jobs, could be reached with a high school diploma, supplemented in some cases by a year or more of business school or junior college. Many interviewees were able to describe the high school coursework they were taking to prepare for their chosen field, and had already decided on a specific postsecondary alternative.

Some interviewees, however, frequently those from middle class backgrounds, had substantially downgraded their future plans as a result of pregnancy and parenthood. Often these were students who had planned to complete college. Career goals that had turned on attaining a four-year degree were postponed indefinitely in a number of cases. Regardless of such prior career plans, the aim now was to finish high school as quickly and easily as possible. For example, several students in one site who had achieved advanced standing prior to pregnancy and parenthood intended to apply for early completion since they had already satisfied most of their graduation requirements. Finishing high school was now seen as essential to finding a well-paying job, whereas graduation had been merely assumed and not thought about before. They anticipated getting relatively unskilled jobs in stores, supermarkets, and offices; most had held such jobs before on a part-time basis. The higher preparenting educational and vocational aims of these students were recognized as realistic in terms of their abilities by school staff who knew them. However, their revised, more modest, postdelivery plans were seen as more realistic now, given their status as parents. As one high-achieving pregnant student saw it, "Being able to make plans and have them work out (when pregnant or a parent) is not so much a matter of luck or ability but of setting modest goals."

These revised plans, while perhaps laudable for their realism, are discouraging for the obvious waste of potential they represent. It is noteworthy that none of those who downwardly revised her plans for the future involved the school in these decisions. None had sought or

[21]Two mothers of older babies reported having given up legal custody for the time being for fear of abusing their child in response to their own stress and frustration.

obtained career guidance. Those who tried to develop specific marketable skills did so on their own.

## CONCLUSIONS

In examining the interview responses of the 121 teenagers in our sample, three points stand out. The first is the enormous diversity among these young people. Only a small percentage match the stereotype of teenage parents that many adult respondents in the same school districts held: low-income, low-achieving, often from a minority background, and with few prospects for the future. They varied on many dimensions. For example:

- Most had not wanted to become pregnant, though a few did.
- Some liked school; others did not.
- Some had a loyal boyfriend; others were unattached or were now involved with someone other than the baby's father.
- Some saw their baby as a prelude to marriage and a "traditional" life style; many had no specific marriage plans.
- A few were well informed about the schooling options open to them; most were not.
- Some reported less ambitious career goals since they became parents; many did not.

The second striking finding in the responses of teenage interviewees was their near consensus on one point: If they had it to do over, nearly all said they would not become pregnant, or else would abort a pregnancy. This suggests that, successful coping and obvious love for their babies notwithstanding, parenthood at an early age is not easy or without serious problems.[22] Most said that if they had known what it was like to be a teenager with a child, they would not have taken the risks that resulted in their pregnancies. Many commented that better sex education would have helped, particularly if it focused less on biology and more on values, goals, assertiveness ("how to say no"), risks, and what parenthood is really like.[23]

The third significant finding concerns decisionmaking processes. Pregnancy and parenthood entail a number of decisions. These decisions, unlike most that teenagers have made prior to that time, have substantial long-term consequences for the direction and quality of their lives. Almost all the teenagers we spoke with made most of these decisions alone or with family members; school involvement was rare and minimal, except for purely programmatic decisions.

The schools were almost never involved in pregnancy management decisions; these decisions were made without considering the educational or vocational implications of various options. Schools were more often involved in school career decisions, but because of the passive stance of regular school staff, many students did not speak to any counselor or staff member before making a decision. They generally made their decision without awareness of all the educational options available. In other cases, school staff steered students toward one option, downplaying others. In a few cases, some options were not disclosed at all.

Decisions to leave school entirely were also typically made without school involvement. In a few cases, an irregular attendance pattern provided a clue that a student might drop out; this clue was not followed up. In other cases, students simply never reappeared after delivery. Followup in these cases was generally *pro forma* if it occurred at all.

A number of interviewees reported that they had altered their short-term, and/or long-term

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[22]It should be remembered that our sample is biased toward "successes." Parenthood is probably even more difficult for other teenagers.

[23]A number of studies show that traditional sex education courses may increase students' level of biological knowledge but the effects on behavior are small (e.g., Zelnik and Kantner, 1977; Finkel and Finkel, 1975).

career goals since pregnancy or delivery. Most cited the need to support the child as the major factor, while others noted that higher education would be difficult if not impossible with a child to take care of. Almost without exception, interviewees made these alterations in their plans without consulting school staff. As a result, they often did not have an optimal plan for developing marketable skills; many hoped to get unskilled jobs after graduation similar to the type they had held part-time to that point.

While school reluctance or concern about the legitimacy of involvement in some of these decisions is understandable, failure to become involved results, in many cases, in poorly informed decision processes and decision outcomes that are beneficial neither to the teenage mother nor her child.

Nevertheless, most of the teenagers in our sample believed that the schools were already doing a great deal, perhaps all they could, to help pregnant and parenting students. These responses underscore the passive, grateful attitudes that characterize this group. Clearly, any impetus for better services cannot be expected to come from teenage parents or their families. Commitment to provide needed services and to develop a more active service delivery system must come from the schools or other agencies.

# Chapter 6

# CONCLUSIONS

This study has focused on four aspects of the schools' response to student pregnancy and parenthood: (1) constraints operating at the federal, state, and local levels that shape district responses to this group; (2) special school-sponsored programs designed to serve the needs of pregnant students and teenage mothers; (3) the response of regular schools to student pregnancy and parenthood; and (4) the impact of all these factors on the decisions of pregnant students and teenage mothers about school continuation and schooling alternatives. The study supports the following general conclusions about the schools' response:

*The schools neither seek nor want an active role in student pregnancy or parenthood.* Given the many constraints on school involvement in this area and the competing demands of other programs and services, such a posture is not surprising. Policy or programmatic involvement in this area often involves the schools in difficult issues such as sex education, contraception, and abortion. Significant portions of school communities believe limited education resources should not be used to meet the needs of pregnant and parenting teenagers; school staff may resent spending their limited time on students they regard as having created barriers to their own success and as morally tainted as well.

*The initiation of a special program for pregnant students and teenage mothers in an LEA depends for the most part on the dedication of a single individual.* This may be a concerned teacher or other practitioner, or it may be the superintendent, who recruits a program director. Given a lack of program leadership at all levels of the policy system, the resulting program generally reflects this person's views about the best model for providing services to pregnant students and teenage mothers. Rarely is a search conducted to learn of alternative models; a lack of program outcome data precludes any weighing of program alternatives on this basis.

*The quality of special programs is uneven, both within and across programs.* Most special programs do an excellent job of providing teenage parents information about pregnancy, child development, and parenting, either through formal coursework or informal learning. Teenage interviewees appeared to retain a great deal of this information and found it to be highly and immediately applicable to their own lives.

In contrast, the academic component of inclusive curriculum programs generally is weak. A lack of appropriate texts, supplies, and equipment frequently exacerbates this weakness. To some extent this underemphasis on academics is intentional—program staff emphasize the overriding importance of relevant learning during the brief period of program enrollment.

The programs in our sample varied substantially in terms of staff qualifications and enthusiasm, staff morale, degree of coordination with community agencies, and quality of services offered. An important factor in program quality is the amount of administrative support the program can draw on. Programs that receive high-level district support are allowed to do their own staff recruiting and find excellent staff; LEA financial commitment contributes to high staff morale and high-quality, continuous services. District support often encourages a higher program profile, which in turn is associated with greater coordination with community agencies.

*Each special program model is effective in meeting some of the diverse needs of pregnant students and teenage mothers—but none is able to meet all of them.* Inclusive curriculum models

offer pregnant teenagers a protective, supportive environment and relevant learning during pregnancy. Program services, however, generally end soon after delivery; new mothers return to regular school, where special help is rarely offered.

Supplementary curriculum programs provide relevant learning to pregnant students and teenage mothers attending regular school; frequently, child care is also provided. Services usually continue until a student completes school or drops out. Because of their on-campus location, however, supplementary curriculum programs cannot offer students the protection of an isolated site.

Noncurricular programs typically provide support and services on a continuing basis beginning in early pregnancy. While in most cases enrollees must attend regular school in order to receive program services, one program in our sample provides services that are not contingent on school enrollment. Like supplementary curriculum programs, noncurricular programs cannot provide pregnant students and teenage mothers the isolation some may want or need.

*A special program usually is viewed as a sufficient LEA response to student pregnancy and parenthood.* As a result of this view, regular school involvement is often limited to helping students enroll in the special program. Student pregnancy and parenthood are rarely discussed in regular schools; regular school staff are often ignorant of the dimensions of the problem. Principals take no leadership role on this issue, and do not establish any expectation that regular school staff should or will actively intervene to help parenting students. Special program staff rarely work actively to overcome these attitudes. In-service training, when available at all, is provided exclusively to special program staff. This policy reinforces the opinion of regular staff that special program staff are best able to handle student pregnancy and parenthood.

As a result of these attitudes and consequent inaction, the schools lose valuable opportunities to help pregnant students and teenage mothers to continue in school and receive the help they need. At several key points, including early detection, decisionmaking with regard to pregnancy resolution and school continuation, and postdelivery return, regular school staff could provide guidance, referral, and support. These actions would reinforce the efforts of the special program by extending the time frame in which help is offered and by making the regular school environment a more supportive one.

*Pregnant students make most decisions concerning pregnancy and school continuation without school staff input.* For the most part, pregnant students neither seek out nor claim to want school staff involvement in pregnancy resolution or school continuation decisions. Interviewees typically reported that pregnancy resolution options were known and discussed with parents and, in some cases, the prospective father and close friends. For most students in our sample, the decision to remain in school was a nondecision in that they never considered the dropout option. Those who had left school did so for one of two sets of reasons: either a long-standing dislike for school (which in several cases resulted in school dropout *prior* to pregnancy) or external circumstances, such as a chronically sick child or lack of child care.

Schooling options during pregnancy were more often discussed with school staff, but often the full range of options was not considered. A number of our interviewees chose a schooling option on the basis of incomplete or inaccurate information.

Neither were school staff involved in the many decisions students made after delivery about child care or career training appropriate to their skills and parent status. In most cases, parenting students were given no extra or unusual attention by regular school staff; generally, they received these services only when there was a special program on-campus in which they were enrolled.

*Very little information is available concerning longer-term outcomes for adolescent parents.*

Many special programs conduct no outcome evaluations at all; those that do are often limited in their focus and time frame by lack of funds, lack of interest among school administrators, and lack of availability of comparison group data. Consequently, little is known about the impact of parenthood on school completion, postsecondary training, or employment. Nor do we know much about the effectiveness of special programs in improving longer-term outcomes for teenage parents. More and better data, ideally longitudinal data on individual parents, are critical to designing and improving school policies and programs, particularly as funds for these efforts become more limited and difficult to obtain.

These conclusions have important implications for policymakers and practitioners. The following sections provide federal, state, and local officials and practitioners with concrete recommendations for future action.

## IMPLICATIONS FOR POLICYMAKERS

Given the many factors constraining any district response to student pregnancy and parenthood, the impetus of a motivated person seems a necessary condition for the establishment of a special program serving this group. Given a leadership vacuum at the federal, state, and local levels, the form and quality of this person's ideas ordinarily determine the form and quality of the district's program, though program quality may be eroded by the lack of LEA support.

As the major funding source for many local programs, state education agencies (SEAs) and other state agencies, such as departments of health, are in a unique position to provide substantive leadership for local efforts in this area, but few have chosen to do so. State departments typically have at most one full-time-equivalent (FTE) responsible for providing such assistance; some states have none at all. In a few states, state department staff members have noted the lack of staff fulfilling these functions and have taken on these responsibilities in addition to their regular jobs.

State departments generally have not adopted coherent strategies for improving the quality of local responses; fewer efforts still have been devoted to motivating a response in districts that have not "self-started." Lack of staff is an enormous and powerful constraint on such efforts; SEA staff in several states have tried to multiply their own influence by establishing informal networks of practitioners around the state.

A stronger state role could help to reduce the people-dependence of local programs, the resulting lack of programs in many LEAs, and the variation in quality across existing programs. State-developed materials that present guidelines, program models, and their implicit priorities could help local staff committed to having a program make more informed decisions about a program model and its implementation. A presentation of potential funding sources for special programs would be of immense value. Strengthening of program evaluation requirements would help the state to build a data base on program effects that could be shared with districts considering program initiation. A more active state role, including community organization and provision of seed money, might encourage inactive districts to make a programmatic response. This strategy has met with some success in one state in our sample because it legitimizes a response while building in a perception that a local program is needed.

Federal staff, particularly those at OAPP, could support state-level efforts to improve local program quality by using federal funds to develop, document, and evaluate a range of program models. Support for new rather than existing programs would increase the number of programs

in existence while allowing some federal input into decisions concerning new program models and appropriate evaluation designs. Federal funds might also be used to develop and strengthen practitioner networks that could provide encouragement and technical assistance to new and established local programs. In our study, we found that such networks often effectively compensate for lack of state or local technical assistance. Federal support for practitioner lobbying efforts would help to focus state and community concern and increase the number of local programs.

At the local level, the superintendent can be a major force in establishing expectations that the district can and should attempt to meet the needs of parenting students. His or her support for a program and commitment to an LEA-wide effort is a critical back-up resource for committed staff in their efforts to serve these students. Small actions, such as asking principals to collect school-level prevalence data and report them to the superintendent and to district staff could help to create a climate of awareness and concern. Other actions, such as provision of funds for inservice training for regular school staff, public support for the district's special program, and flexibility in the implementation of a range of absence, transfer, and graduation policies would communicate the superintendent's concern to staff and the larger community and contribute to the perceived legitimacy of district support for parenting students.

At the school site level, the principal could have much the same effect by discussing student pregnancy and parenthood and emphasizing the positive actions that regular school staff can take. In most schools the principal's involvement in student pregnancy and parenthood is limited to delegating full responsibility for handling pregnancies to the nurse or counselors. Such a designation often signals to the rest of the staff that this is a low-priority matter for which they need take no responsibility. When the principal is actively involved, however—keeping track of numbers of pregnancies, receiving and reading reports of the disposition of pregnancies, setting up and monitoring policies concerning pregnancy—the principal communicates his or her own concern and helps to establish an expectation that staff will be involved with parenting students.

## IMPLICATIONS FOR PRACTITIONERS

There is clearly a role for the schools in student pregnancy and parenthood. For even the most motivated teenage parents, a host of extrinsic problems can make school continuation difficult; for those less motivated they may make it impossible. At the same time, the growing fiscal problems that school districts face, combined with a lack of incentives to serve this group, make schools an often reluctant partner in efforts to meet the needs of parenting students.

Some thought needs to be given to alternative methods of providing services to pregnant students and teenage mothers. The inclusive curriculum program model, which for many is synonymous with special programs for pregnant students and teenage mothers, is often viewed as costly and inefficient. While such programs provide unique services, in particular an isolated, protective school environment, there are other program models that can provide many services at less cost to the district. Some practitioners are questioning the need for LEAs to provide services already available in the community. Further, they feel that provision of these services in the context of special programs is ultimately counterproductive, because such programs are short-term while the need for services is not. A more lasting and valuable service is to teach pregnant students and teenage mothers how to identify, locate and use existing

community resources. Such an approach may also meet with greater LEA support, since program costs are often less and responsibility is shared.[1]

Adolescents are also changing. Though in most cases their needs are great, pregnancy is not as embarrassing as it once was to many; the isolation afforded by an inclusive curriculum program may be seen as a negative rather than a positive program feature. From the perspective of the pregnant student, a choice of service models would be ideal; they could then match their needs to available programs without having to compromise educational progress or lose needed services. The provision of multiple service alternatives, however, may meet opposition because of costs, duplication of services, or professional jealousies. Some consideration of program models that link existing community services rather than supplying them directly may make multiple program models in an LEA more acceptable in a period of fiscal decline.

In their efforts to have an impact in the district, special program planners frequently ignore regular school staff. Only one program in our sample solicited active involvement from this group, but it is significant that some faculty in each contacted school were willing to participate when asked. Regular school staff directly or indirectly play a role in every student's pregnancy by providing or withholding information, counseling, and support. No matter what model the special program follows, regular staff can reinforce and multiply its effect or diminish it through their actions and inactions. Time spent eliciting the active cooperation of regular faculty, nurses, and counselors is time well spent.

In sum, school response to student pregnancy and parenthood is often limited or nonexistent. An array of constraints has fostered a leadership vacuum at all three levels of the policy system. As a result, there is little institutional impetus to make a response; instead, LEA response depends on the presence and drive of a motivated individual. When a program is established, it is generally viewed as a sufficient response of itself to student pregnancy and parenthood. Service gaps inherent in the program model are rarely filled by regular school staff. A more cooperative approach in many more districts is needed to meet the needs of school-age parents. Leadership and support from all three levels of government are needed to broaden and improve this response.

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[1]Some services provided in inclusive curriculum programs are paid for by community agencies, so no cost savings would be realized in these cases if services were returned to the community. However, responsibility would be diffused to a greater extent.

# Appendix A

# STUDY METHODS

## SAMPLE SELECTION

Given the exploratory nature of the study, a statistical sampling procedure was ruled out. Instead, we drew a purposive sample designed to maximize both the breadth of our results and the amount we could learn from each site.

In selecting our sample, we followed the diversity strategy described by Murphy (1980). First, we sought to identify important dimensions along which school districts might vary. An informal telephone survey of practitioners and other knowledgeable people in this area early in the project was most helpful in this regard. Respondents to this survey described policy and operations in their home districts and suggested a number of factors they felt would be important in analyzing a district's policies, e.g., level of community concern about teenage pregnancy and district involvement with sex education. Several previous Rand studies in school districts suggested more general dimensions, e.g., centrality of the issue to LEA concerns, superintendent leadership, and state-level policies.

The possible importance of state policy and stance on student pregnancy and parenthood led us to select our sample in two stages. In the first stage, we selected four states; in the second phase, we selected two districts within each of these states.

The state sample was selected to assure variation in state strategies and characteristics that we believed might influence local policies and behavior. In selecting states, we sought variation in three characteristics:

- State Department of Education policy and level of support for local efforts to serve pregnant students and teenage mothers,
- The presence of formal and informal statewide networking about school-age pregnancy and parenthood, and
- Presence of advocacy groups at the state level.

We also sought to achieve some variation in geographic location, State Education Agency (SEA) innovativeness, and state commitment to education. A final consideration in the selection of the state sample was that there be a sufficient number and variety of local programs so that our selection of local districts would not be unduly constrained. Information about programs was obtained from state department staff, district staff, experts in the area, and published reports, including the National Directory of Services for School Age Parents (NACSAP, 1976).

Once the states to be visited were chosen, we proceeded to select two LEAs within each selected state for site visits. In selecting local districts, we sought to achieve some diversity both within and between states in terms of:

- Rural/urban location and clientele,
- District size,[1]

[1]Districts with very small enrollments (<4000) were excluded because the telephone survey results indicated that such districts rarely made any response at all to student pregnancy and parenthood.

- Special program model,
- Community political ethos, and
- Level of district support for the program.

To the extent possible, we made our selections of LEAs iteratively, so that feedback from early visits could inform later selections.

Upon completion of our fieldwork visits to the four selected state capitals and the eight LEAs, we proceeded to identify two "exemplary" LEAs to visit in the final round of fieldwork. As discussed in detail in Chap. 3, defining and selecting these LEAs was difficult since we lacked the dropout and program outcome data required to make an informed choice based on the relative effectiveness of program outcomes. Instead, in selecting these sites we chose from among LEAs with innovative program models that appeared to be effective in terms of a set of process criteria established over the course of the Phase I fieldwork. These process criteria included:

- Percentage of eligible students served,
- Level of coordination with other community agencies involved in serving this population,
- Quality of resources available to the program,
- Level of district and community support, and
- Extent and quality of services provided.

The state location of exemplary programs was not considered in their selection. (See Chap. 3 for further discussion concerning the selection of the exemplary programs.)

At the last minute, we chose an eleventh LEA for a brief site visit. This site, located in a previously unvisited state, houses a program oriented toward student mothers that includes a child care center in the high school building. Earlier site visits suggested that increasing expenditures and a growing unwillingness on the part of pregnant students to leave regular schools may make on-campus programs a preferred program model in the future. By adding another program of this type to our study sample, conclusions about the utility of the in-school program model would be based on a wider range of programs.

## ACCESS

Although we did not have to eliminate a selected site because of noncooperation, access to the LEAs in our sample was frequently problematic. We lacked the stick of mandated involvement in a federal program evaluation; for many, our carrot (sharing of knowledge and information) was insignificant compared with the perceived risks of participation. One superintendent told us directly that a visit by Rand staff might bring the problem unwanted publicity, and a few superintendents put limits on the people we could speak to in order to reduce these risks. A few program heads initially resented the time involved, and a number were rightly concerned about the privacy of their enrollees. In several cases, LEA administrators noted they were "over-visited" and wondered how much longer they could allow staff to be unpaid research subjects.

Ultimately, however, all the sites to which we applied for access permitted us to conduct fieldwork in their midst. Once on site, we were treated with exceptional courtesy and good will in every case. We are most grateful for the cooperation of our respondents, without whose help this study could not have been conducted.

## FIELDWORK

During the school year 1979-80, a two-person team spent 3 to 5 days in each district.[2] A total of 354 respondents were interviewed. These interviews included:

010 school superintendents or assistant superintendents;
017 supervisors for handicapped, special programs, school health, or social work;
005 pupil personnel services directors;
016 school board members;
035 high school and junior high school principals and assistant principals;
038 teachers;
033 counselors;
016 school nurses;
004 school social workers;
024 special program staff;
024 community health care or social service providers;
011 other knowledgeable people in the community, such as representatives of Planned Parenthood, March of Dimes, or local church groups;
104 pregnant and parenting teenagers attending special programs and regular school programs; and
017 pregnant and parenting teenagers who had dropped out of school.

Field staff used open-ended field interview guides in conducting interviews and asked questions that tapped each respondent's unique expertise and perspective. Because most interviewers were quite familiar with the workings of schools and with teenage pregnancy, they were encouraged to pursue independent lines of inquiry they believed would be interesting and useful to the project.[3]

On the average, interviews lasted one and a half hours. Interviews with adult respondents focused on the nature of formal and informal policies surrounding student pregnancy and parenthood, the establishment and operations of the special program, and the community context for these efforts. Interviews with teenagers focused on personal and peer responses to pregnancy and parenthood, pregnancy and school career decisionmaking, and evaluation of the special and regular school program in terms of ability to serve their needs.

In addition to these interviews in the 11 school districts, field staff also spent 1 to 2 days in each of four state capitals. Here they interviewed a total of 13 people, including:

4 state health department employees or consultants,
2 members of state legislatures,
2 members of state boards of education,
1 member of the governor's staff,
1 staff member of a legislative committee,
2 state department of education staff members, and
1 state-local volunteer organizer.

The purpose of these interviews was to obtain a state-level perspective on state and local policy and practice and to determine whether the pregnancy and parenthood policies and procedures in the districts we visited were typical of others in the state.

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[2]In the case of one very small district only one interviewer visited the site.

[3]The members of the field staff included a school counselor, a former school psychologist, two clinical psychologists, and a former high school teacher.

At the conclusion of the fieldwork, a case study (between 40 and 100 pages in length) was written for each site. A detailed outline was used in writing case studies to ensure that reports contained comparable information that allowed for comparisons across districts.

# Appendix B

## METHODS AND ASSUMPTIONS UNDERLYING PROGRAM EXPENDITURE ANALYSES

Because this was not primarily a cost-analysis study, we had neither the resources nor inclination to conduct a full-fledged analysis of the cost of special programs. However, we believed that some analysis of their costs might be of help to policymakers and to LEAs considering whether to initiate or modify a special program designed to serve pregnant students and teenage mothers. In particular, analyses that included a range of program models might encourage districts to consider a variety of approaches to meeting the needs of pregnant students and teenage mothers.

We address three questions in our analysis:

1. How much did the special programs in our sample spend per enrollee? Here we were interested in total special program costs per participant.
2. How much more was spent for special program enrollees than for regular students? Here we compared the total annual resources devoted to pregnant students (who are in the special program part of the year and in the regular program the rest) with the total annual expenditures for the average regular student.
3. How much more did the LEA have to expend for special program enrollees than for regular students? Here we were interested in comparing the district's nonreimbursed expenditures for special students with those for regular students.

### DATA COLLECTION

In each site, fieldworkers collected the following data:

*Regular Program*

- Pupil/teacher ratio
- School-level services available, e.g., 1 nurse, 4 counselors
- School enrollment[1]
- School-level administration, e.g., 1 principal, 2 assistant principals, 1 secretary

*Special Program*

- Teaching staff (in FTEs)
- Service staff (in FTEs), e.g., 0.5 nurse, 2 social workers
- Mean daily enrollment
- Total yearly enrollment[2]
- Administrative staff, e.g., 1 director, 0.5 secretary

[1]When there was more than one high school, enrollment and school-level services were averaged across high schools in the district.

[2]Both mean and yearly enrollment figures were collected in special programs because most enrollees stay less than one year. As a result, yearly enrollment figures overestimate enrollment at any given time.

- Outside funds received by the program[3]
- Percent of periods each day enrollees attend the special program (in the case of noninclusive programs)

Some obvious costs were not considered in the analysis because they would have increased its complexity while adding only a marginal increase in accuracy. Among these costs are:

- Central administrative costs, e.g., the superintendent's salary. We surmised that these costs were fairly equal per pupil across regular schools and special programs.
- Plant operations and maintenance costs. While some inclusive curriculum programs allotted far more space per enrollee than did regular schools, the special program sites were generally inferior. Therefore, we felt that building and maintenance costs were fairly equal.
- Equipment costs. In general, there was more equipment in better repair in regular schools. On the other hand, some programs had specialized costly equipment that was in good repair. In addition, the annual cost of equipment per pupil over the life of the equipment is usually very small compared with other costs, e.g., personnel.

These data were supplemented by salary data published in *Scheduled Salaries for Professional Personnel in Public Schools, 1979-80* (Educational Research Service, 1980). This volume lists salaries by districts within states. In cases where a fieldwork district was not listed, an LEA in the same state with a comparable enrollment was used.[4]

High and low salaries for each position were published; we used the mean of these figures as our salary figure. Use of such average salaries eliminated the effects of price differences across areas, which is consistent with our interest in program effects rather than price effects. Use of average salaries also eliminated potentially large cost differences which would occur when new, inexperienced, and less expensive staff are used in some programs while older, more experienced, and more expensive staff are used in others. As a result, our final figures are not precise figures for the year under study, but rather represent average expenditures over a period of time.

## DATA ANALYSIS

To address the three questions posed by the cost analysis, seven calculations had to be made:

1. Annual per pupil expenditure for regular students (PPE);
2. Annual special program expenditure per pupil in yearly enrollment;
3. Total outside funds earmarked for the special program;
4. Total annual expenditure per special program enrollee;
5. Total annual unreimbursed expenditure per special program enrollee;
6. Ratio of total annual expenditure per special program enrollee to total annual expenditure per regular student (total cost ratio); and

[3]If nonmonetary resources are provided, e.g., a half-time counselor is provided by the Department of Social Services, the value of her services was estimated using figures presented in *Scheduled Salaries for Professional Personnel in Public Schools, 1979-80* (Educational Research Service, 1980).

[4]Some salaries were not included in this volume. In these cases, a salary figure was derived based on a published salary. For example, an aide salary was calculated = 0.6 teacher, a Licensed Vocational Nurse = 0.6 nurse, and a secretary = aide.

7. Ratio of total annual unreimbursed expenditure per special program enrollee to total annual expenditure per regular student (district cost ratio).

Each calculation is discussed below in turn.

1. Annual per pupil expenditure for regular student (PPE) was calculated as the sum of a, b, and c, where:

a. Classroom cost = teacher salary ÷ average class size.
b. Services cost = the sum of counselor, social worker, and nurse salaries ÷ average school enrollment.
c. Administrative cost = the sum of principal, assistant principal, and secretary salaries ÷ average school enrollment.

2. Annual special program expenditure per pupil in yearly enrollment was calculated as the sum of e, f, and g, where:

e. Staffing costs = teachers' + aides' salaries ÷ total yearly enrollment.
f. Services costs = social worker + nurse + counselor salaries ÷ total yearly enrollment.
g. Administrative costs = director + secretary salaries ÷ total yearly enrollment.

3. Total outside funds earmarked for the special program was calculated as the sum of state, federal, and local funds earmarked for the program as well as the value of in-kind services provided for the program.

4. Total annual expenditure per special program enrollee comprises two elements: (1) total expenditure per special program enrollee while in the special program, and (2) total expenditure per special enrollee while that student is in regular school. By including these two elements, the calculation takes into account that, on average, inclusive curriculum program enrollees remain in the program for less than a full school year and that in supplementary curriculum programs enrollees spend only part of each day in the program.

Average total expenditure per special program enrollee while in the special program is equal to annual special program expenditure per pupil in yearly enrollment (see Formula 2, above).

Total expenditure per special program enrollee while attending regular school was calculated as follows:

a. Average daily special program enrollment was multiplied by the number of days in the school year and by the percentage of the school day spent in the special program (in the case of supplementary curriculum programs).[5]
b. The resulting figure was then divided by total annual special program enrollment. The quotient is the number of school days spent in the special program by the average special program enrollee.
c. The number of days spent in the special program (b) was then subtracted from the total number of days in the school year. The result is the average number of school days spent by special program enrollees in the regular program.
d. Number of days in the regular program was divided by the length of the school year to yield the average percentage of time the special student was in the regular program.
e. Finally, the percentage of time in the regular program (d) was multiplied by annual

[5]Inclusive curriculum programs that had shortened days were treated as full-day programs since they replaced a full school day.

per pupil expenditure for regular students (Formula 1 above). The result is the *average expenditure for a special program enrollee during the time she spends in regular classes*; this figure was then added to the annual *special program expenditure per pupil in yearly enrollment* (Formula 2, above) to determine the total annual expenditure per special program enrollee.

5. Total annual unreimbursed expenditure per special program enrollee. This calculation is similar to the one used in Formula 4, but in this case, the expenditure per special program enrollee is the unreimbursed cost to the LEA, rather than total program cost. The unreimbursed cost per special enrollee is calculated by subtracting total outside funds earmarked for the program (Formula 3, above) divided by total yearly special program enrollment from Annual Special Program Expenditure Per Pupil in Yearly Enrollment (Formula 2, above). This figure is then added to the total expenditure per special program enrollee while attending regular school (calculated above). The result is the total annual unreimbursed expenditure per special program enrollee.

6. Ratio of total annual expenditure per special program enrollee to total annual expenditure per regular student (total cost ratio). This ratio allows a quick comparison between expenditures for regular and special program enrollees. It is calculated by dividing total annual expenditure per special program enrollee (Formula 4) by Per Pupil Expenditure (Formula 1). When the result is greater than 1.0, it indicates that expenditures for special program enrollees are on average higher than expenditures for regular students. A result = 1.0 would indicate no difference in expenditures between regular and special program enrollees.

7. Ratio of total annual unreimbursed expenditure per special program enrollee to total annual expenditure per regular student (district cost ratio). This ratio allows a quick comparison between expenditures per special program enrollee not covered by special outside funds and district expenditures per regular student. Hence, it reflects the often substantial amount of money that special programs receive from outside sources and the consequent reduction in the district's financial share in the program. The ratio is calculated by dividing total annual unreimbursed expenditure per special program enrollee (Formula 5) by per pupil expenditure (Formula 1). The resulting ratio may be more than 1.0, indicating that the district expends more for special program students than for regular enrollees, or it may be less than 1.0, indicating that the district spends less for special program students than for regular enrollees.

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